

HARVARD MEDICAL

ALUMNI BULLETIN

WINTER 1982

LIFE IS SHORT
AND THE ART LONG
THE OCCASION INSTANT
EXPERIMENT PERILOUS
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stress

Medicine's Occupational
Hazard?



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HARVARD MEDICAL

ALUMNI BULLETIN/WINTER 1982/VOL. 56, NO. 1

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INSIDE H.M.A.B.

In 1980 three members of the Harvard Medical School Class of '67 died, two by suicide, bringing the mortality of that group to seven. In the aftermath of these deaths, a stream of letters came into the *Bulletin* office from other graduates of 1967; they registered grief, confusion, fear, perhaps guilt. "Is there a problem with who is selected for Harvard or with the educational experience or with career expectations?" one of them wrote. "Does Harvard pay enough attention to teaching students and alumni how to cope with stress?"

While the class of '67 statistics are inconclusive, the literature contains a number of studies which indicate high rates of suicide, alcoholism and drug abuse among doctors. This issue of the *Bulletin* is concerned not only with this category—the so-called "impaired physician"—but also with the less dramatic stresses that affect many physicians and detract from the quality of their personal and professional lives.

In the February 25 issue of the *New England Journal of Medicine*, Jack D. McHue of the University of North Carolina linked the stresses of medicine to several conditions unique to the profession: involvement in highly emotional areas such as suffering, fear, sexuality and death, which are governed by strong cultural codes for behavior; inadequate training for certain professional tasks, as basic as the management of "problem" patients; and demands that cannot reasonably be met—the need for certainty when current medical knowledge allows only approximation.

The first and last of these conditions would appear to be with us, for better or for worse, as long as death, disease and suffering remain a part of human experience. But "inadequate training for fundamental professional tasks" is surely remediable, if only the commitment is made to get back to basics. And surely a system of education which teaches how to care for others must also encourage physicians to be alert to, and acknowledge, danger signals in themselves and their colleagues.

We would like to thank all of our contributors to this issue, especially those from the class of '67, who have impelled us to confront a painful, complex, and often overlooked subject.

—LWS

HARVARD MEDICAL

ALUMNI BULLETIN

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The *Harvard Medical Alumni Bulletin* is published quarterly at 25 Shattuck Street, Boston, Mass. 02115. © by the Harvard Medical School Alumni Association. Third class postage paid at Boston, Massachusetts. Postmaster, send form 3579 to 25 Shattuck Street, Boston, Mass. 02115. ISSN 0191-7757.

LETTERS

The Premed Syndrome: Second Opinions

Reactions and Abreactions

The same week recently brought to my mailbox the Fall 1981 issue of the *Alumni Bulletin* and articles about the "Darsee affair" in *Science* and *Newsweek*. I can't help but think that the "premed syndrome" described in the *Bulletin* might be causally related to this latest scandal in academic medicine as the pressure cooker of Chem 20 becomes no more than a novitiate for the competitiveness of NIH research funding. In both instances, the narrowly trained and narrow-minded student, be he 19 years of age or 30, may lose sight of the appropriate end and pursue it with unjustifiable means.

Drs. Ahrens and Akins have provided us with a thoughtful exploration of the problem of premedical education at Harvard College and have made a number of recommendations for improving the current climate there. I trust that a future issue of the *Bulletin* will provide us with a full report of the Ross committee appointed by Dean Tosteson and with a thorough discussion of the issues involved in the "Darsee affair." If we cannot properly teach those who would be students or faculty at HMS that intellectual honesty is basic to the science of caring, we will have failed as physicians and educators, regardless of how many millions of dollars in grants we hold.

Philip J. Rettig '72

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the HMAB and may be edited, although we are unable to provide pre-publication proofs.

My daughter gave me a copy of the Fall 1981 issue of the *Harvard Medical Alumni Bulletin*. I found it most interesting in its concept and presentation. I brought it into our Dean's staff meeting where it stimulated a great deal of interest, since we have been most concerned here at Penn with the same problem.

The issue was a great idea, and you did an excellent job. The notion to include separate essays was a very good one (although I did abreact to the piece by Kenneth Klein). I think the report will be of great interest to the folk in many of our medical schools who are concerned with the nature of "The Race to Medical School."

Patrick B. Storey
Professor of Medicine
Associate Dean
University of Pennsylvania
Medical Center

You stated that letters are welcome, so here is mine from Utah.

I have kept most of the HMS *Alumni Bulletins* over the years as a history of Harvard Medical School. Each *Bulletin* had a place in my waiting room, but times have changed. The recent issues lack the professional contents becoming to such a great institution. The cover is most unattractive.

After reading about the Premed Syndrome—whatever that is—and the complicated admission requirements, I was most confused and wondered how Harvard Medical School graduated so many good doctors in the past.

Return to the format *Bulletins* of the seventies. A photograph (*sic*) including the life and history of a distinguished alumnus would be a good addition to the publication. For names the list is long.

J. Russell Smith '32

I was delighted with the report to the Alumni Council on preparation for and admission to Medical School. Although I was a history major and have never regretted it, there have been times when I wished I had had another term of calculus.

I would like to request one copy for a daughter who is thinking of applying to medical school, one copy for a friend on our admissions committee, and one copy for our Dean (SUNY at Buffalo School of Medicine).

David G. Greene '40

The "premed syndrome" will vanish when college students learn that the "doctor surplus" of the 1990's is real. Modern premeds are not stupid; and the prospect of scarce jobs and large educational debts will have little appeal. As the cut-throat competition shifts to prebusiness and preengineering, medical schools will have to recruit competent scientists who enjoy caring for people.

While much of the *Bulletin* was devoted to showing how HMS is still succeeding in finding and training other-directed and multi-talented physicians, the article on backing into medicine by Klein '75 was a sad reflection on the modern crop. His use of "I" fifty times in one page (three times in one sentence) suggests Homeric self-fixation. However, his open disdain for premeds hardly augers well for a career which depends on referrals from mere doctors. Klein's literary style might be less tedious if he read the following:

Pity no doctor can cure what is wrong, When we talk of ourselves and our "I's" are too strong.

Paul Wheeler '61

I was highly impressed with the very informative content of the Fall issue of the *HMAB* regarding premedical studies. As a high school senior interested in

medicine, I have never more fully been able to understand what involvement as a premedical student entails. The article by Patricia Walters and the interview with Robert Kiely have revealed more than reams of college admissions office materials.

**Pamela Woodard
(Hopefully the Class of 1990)**

It saddens me that the *Bulletin* seems to have degenerated into a series of shrill, sophomoric essays by medical undergraduates who fancy themselves to be "dehumanized," or who wonder if they can survive the 24-hour-a-day assaults of the HMS curriculum, or who revel in the (largely self-inflicted?) pain of recalling the academic "torture" of their premedical studies.

Has the whole HMS student body become a group of dyspeptic little Hamlets who mope about constantly ruminating and soul searching? They seem unable to distinguish between being *serious* (but only when the occasion demands) and being constantly *solemn*.

My class was hardly a solemn one. Most of us were several years older than students of corresponding classes today. Many of us had had our education interrupted by service in the military. Many, like myself, had survived combat and had commanded groups of men in battle. We were certainly more relaxed in our studies, and, it seems, in our leisure time as well.

For most of us, our "premed" education had been rather catch-as-catch-can, *ad hoc*, and fortuitous. Many of us did not decide to enter medicine until late in our military service (I had been commissioned as a line officer in the Navy for three years before I so decided, and was accepted by four medical schools (Harvard, Johns Hopkins, Pennsylvania, and McGill) within two months of application. Three of the four accepted me "sight unseen" without an interview. I certainly didn't have very many travel expenses!

My class in general, and I in particular, hardly found the HMS years grim, which now appears to be the case if one believes what's printed in the *Bulletin*. For example, while in medical school I found more than enough time to shoot on a rifle team; do some serious mountaineering; play the cello in a string ensemble; do some gunsmithing "for fun and profit"; attend numerous lectures in *non-medical* subjects at the various Hub universities; frequent the art museum; attend once or twice weekly cinemas, symphony concerts or operas; audit a foreign language course; and plant

twenty-five acres of pine forest. I even took an evening course in welding at a nearby technical institute and spent a summer at the University of Oslo taking oceanography and other *non-medical* courses.

And (ah, yes!) those damn-near-all-night-long Vanderbilt Hall parties! Not a few of them were so boisterous that they were broken up by the local gendarmerie. Nor should one forget the several ribaldly Rabelaisian Aesculapian show skits to which I added my hammy two-cents-worth. (Passing thought: François Rabelais was himself a physician, and could hardly be described as "dehumanized.")

Added to the above was my courting of four delightful ladies (*seriatim*, not simultaneously), one of whom I married.

By the grace of God and perhaps because of such "distractions" as the above, rather than in spite of them, I still managed to graduate near the top of my class, with my humanity augmented, rather than diminished, I suspect.

Please, let's return to the old *Bulletin*, and have something which "neither starveth the soul nor outrageth the intellect."

Merrill J. King '52

An Idea Whose Time Has Come

In these times of economic malaise, we are pleased to report a new fiscal strategy, outlined in the following letter by William (Dave) Winter '47. Move over, David Stockman!

Dear _____ :

Were you not a physician, the fee I would have charged for medical care to your family in recent months would have been about _____. I have no intention of charging physicians for medical services, but I have a suggestion that would mean a great deal more to me than an annual gift, and which would mean infinitely more to the recipients.

Since 1968 Harvard Medical School has been striving to maintain a fund to help finance medical education for disadvantaged students of various minority groups. As more disadvantaged students with appropriate training come along, the need for increase in this fund grows rapidly.

If you should be willing and able to contribute to this tax-deductible fund an amount proportionate to the cost of the medical care received, I should be very grateful. Please send any check, payable to Harvard University, to:

Fund for Disadvantaged Students
Harvard Medical School
25 Shattuck Street
Boston, MA 02115

and make reference to this letter.
Many thanks.

Yours Sincerely,

William D. Winter, Jr., M.D.
Dedham Medical Associates
One Lyons Street
Dedham, MA 02026

Dear Dr. Winter:

We have learned of your effort to have physician patients send to the Harvard Medical Alumni Fund amounts which would otherwise comprise professional courtesy gifts to you. I would like to acknowledge on behalf of Dean Tosteson and Harvard Medical School, this extraordinary generosity on your part. To broaden its impact, I wonder whether you would be willing to have me mention it in the *Harvard Medical Alumni Bulletin*. I believe that if more graduates knew of this approach and possibility, they would join you in finding new money both for the program for disadvantaged students, and for other needs of the School. Certainly HMS needs such help in many areas, and your approach generalized, could have a big impact. Our deepest thanks.

Sincerely,

Daniel D. Federman, M.D.

The interesting issue of the *Alumni Bulletin* devoted to "The Race to Medical School" seems to contain three erroneous assumptions:

Most of the authors imply that an undergraduate program with many science courses produces a narrow type of student lacking the humanity desired in a physician. Only Prof. Harrison pointed out that the clear thinking resulting from an education in mathematics and the sciences is dehumanizing only to those who equate humane with muddle-minded. Is a physician inhumane, who by clear scientific thinking, makes a prompt, accurate diagnosis and spares a patient days or even months of apprehension and suffering?

The second error is the repeated statement that organic chemistry is an exercise in memorizing. Courses in foreign language or in history are far more dependent on brute memory, e.g. vocabulary lists, grammatical rules, dates, names of kings and generals, etc. Organic chemistry, with its emphasis on synthesis, is an exercise in memory only for those students who lack the ability to think in the terms required for subsequent understanding of the disease process.

Finally, the experience that may produce a narrow, inhumane physician comes not from the premedical years but from the medical school itself. Still vivid in my memory is the shock of my contacts with the faculty of the preclinical years. Almost without exception every teacher presented empirical catalogues of facts which my classmates eagerly devoured and regurgitated on examinations in order to achieve good grades. Conversation between classes or in Vanderbilt Hall was restricted to medicine, so that one never heard any mention of literature, music, art or politics except on one occasion: Two of the fellows expressed their admiration for Mussolini because he made the trains run on time.

Perhaps with the passage of time there have been radical changes in the cultural attitudes at HMS. On the West coast things now seem to be worse. Our recent graduates usually lack the human interest required for taking a decent history and performing a proper physical examination. Doctor-patient contact is restricted to the expression of one or two symptoms, enabling the physician to order a host of esoteric and expensive tests from which diagnosis and treatment may be derived.

Theodore B. Massell '31

Outfoxed

In recent years we have become accustomed to all sorts of tom-foolery around HMS, especially at the *Bulletin* since John Brooks relinquished his iron (and delightful) grasp on the magazine. Some things, however, I just cannot let pass unremarked, to wit, the Editor's Note, page 4, Fall '81: "A hue and cry can be great fun, unless you happen to be the fox."

A glance at your seventh New Collegiate will tell you that the "hue and cry" had nothing to do with fox-hunting: It was, rather, the "pursuit of a felon by the citizenry." In the year 1382, if you were murdered, your neighbor couldn't dial 911 to summon the cops, so neighbors of good will "raised the hue and cry," pursued, caught, and hanged the killer without benefit of William Kunstler, Esq.

All things considered, I think this was a salutary practice. For one thing, it went a long way toward preventing overcrowding in the prisons. On the other hand, it caused widespread unemployment in the legal profession.

Kevin M. Cosgrove '43

Editor's Note: *Dr. Cosgrove is quite right in his claim that "hue and cry" has nothing to do with fox hunting; on the other hand, could one really be expected to have written, "A hue and a cry can be great fun unless you happen to be the felon?" Now that the error has achieved perpetuity on the pages of the Bulletin, perhaps the fox-hunting association will prevail.*

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HARVARD MEDICAL SCHOOL
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BOOK MARKS

A Woman in the Men's Club Known as Surgery

THE MAKING OF A WOMAN SURGEON, by Elizabeth Morgan, G.P. Putnam's Sons, N.Y., 1980, and Berkley Books, N.Y., 1981.

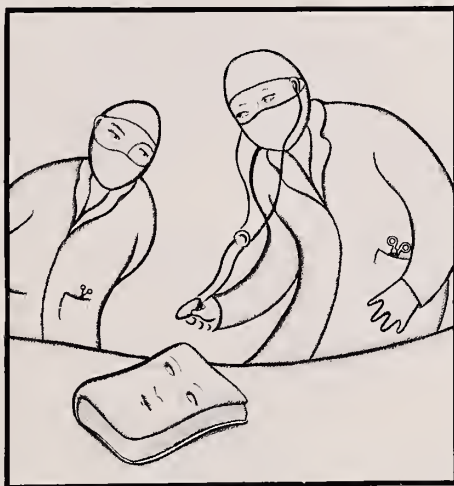
by Dorene O'Hara '83

The cover of *The Making of a Woman Surgeon* advertises that author Elizabeth Morgan "learned women surgeons don't have to be as good as men—they have to be better!" Perhaps. But in fact that assertion has little to do with the series of brief, vignette-like chapters which make up this book, and which neither reach such conclusions nor focus on barriers she encountered.

Morgan's intent, according to her introduction, is to describe her growth from medical student to surgeon over eleven years. "I enjoyed my surgical training, but it was very hard," she tells us. "I want you to know what it is like." The implication is that she will evoke a sense of passage, and of her experience as a woman in a male-dominated field.

The choice of title calls to mind *The Making of a Surgeon*, written by William Nolen in 1970. His book was recommended by the *Saturday Review* as "an intensely human record of a young surgeon's apprenticeship." And it is. Since Morgan borrowed Nolen's title, and the two books deal with similar subject matter in a chronicle format, it is not unreasonable to think that the revealing, thoughtful and inspiring drama of Nolen's book will be repeated in some fashion here. But unfortunately this never happens. Morgan does not paint enough of a rounded picture of herself, her patients, her coworkers or their interactions with each other to honestly tell us "what it is like."

What Morgan does do is to capture—from a strangely empty perspective—some of the elements which could have contributed to a full picture. She conveys well the excitement she felt in her first surgical experience—working hard, often losing sleep and missing meals, but loving the drama of the operating room.



In describing moving interactions between physicians and patients, in talking about life and death, Morgan is unable or unwilling to discuss the effects of these profound issues on herself.

The book is animated with an interesting cast of surgical characters: amusing, lovable, and abusive patients; fellow residents; brilliant and caring surgeons, and one or two money-hungry or insensitive ones. And most vivid are the emergency and operating room scenes, as we watch the young surgeon learn the profession through experience.

Morgan stops short, however, of revealing the significance of what she

chooses to relate. The reader doesn't discover what motivates her, and she frankly doesn't seem to know. Surgery fascinates her, she tells us at the outset, and then comments, "I was not sure where the idea had come from but . . . surgery appealed to me more than ever." We expect to become a part of a courageous woman's struggle with life and death, and of her personal and professional growth: we are left with a collection of incidents reported in a remarkably detached fashion.

One such incident involves a fellow woman student, Cathy, who begins to drift apart from the other students early in their clinical years, often voicing concern about her ability to be a good doctor. When Cathy attempts suicide, Morgan records other people's reactions: Male medical students and the psychiatrist attribute Cathy's attempt to the stress of medical school for women and to a recent breakup with a boyfriend. Another woman medical student responds, "I hope these shrinks stop talking about a woman medical student adjustment reaction and get real with her. The male ego is unbelievable. I wouldn't kill myself over a guy, and you wouldn't either, but these guys are willing to believe anything."

When Cathy succeeds in a second suicide attempt, Morgan briefly speculates about Cathy's feelings of loneliness and isolation, but dismisses it all with the remark, "Cathy's suicide was too much for me to understand." Then we're off to her internship interviews. Morgan must have felt something else—sadness, disbelief, fear, guilt, and perhaps anger at Cathy for turning away her offers of help. The reader is left tentatively agreeing with the other woman student that it was not merely medical school that killed Cathy, but we never find out if Morgan herself agrees.

There is a similar lack of reflection in Morgan's portrayal of her first fatal mistake. Early in her internship, a preop patient reports a spell of chest pain, and

Morgan, exhausted and busy, does not order an EKG because the patient then says he feels fine. The next day in recovery Morgan overhears two surgeons talking: "He just arrested on the table . . . He had a massive heart attack last night and he complained of chest pain, but the stupid intern just ignored it."

Morgan writes that she wanted to quit right then, and that she's never forgotten that patient. She also wouldn't give up and let others call her an hysterical female either.

Shouldn't there be more? Every physician must face the fact that doctors are human beings who make mistakes and that patients may suffer injury or death because of them. It has nothing to do with being male or female. It is a doctor's burden. Clearly the answer does not lie in giving up. The ability to go on, however, comes with reflection about how one will face mistakes and how one will try to prevent them in the future.

In describing potentially moving interactions between physicians and their patients, in talking about life and death, Morgan is unable or unwilling to talk about the effects of these profound issues on herself. Nowhere does she reveal her growth as a physician or as a person.

When Morgan finds herself bitter and angry near the end of her residency, the book becomes a disappointment—and leaves this female medical student who intends a career in surgery frightened and sad. The promises of the title, introduction, and few vivid moments go unfulfilled. Morgan wonders if she's wasted the decade of her twenties. She has had no social life. And she is resentful of the vast amount of routine work a resident is forced to do. She suggests that the grueling training period breeds cynicism. The reader has not, however, been shown the development of these feelings.

A few short chapters later, when Morgan says of a young woman intern, "I could only hope that she would learn, sooner than I had, and with less struggle, how to be a surgeon and a woman at the same time," the reader feels equally left out. Is *that* what she has been getting at?

Morgan's self-portrait is not that of an uncaring physician or a careless or unscrupulous surgeon. But in reality it is not a portrait at all—it is a sketch, a chronicle of events recorded by a detached observer.

Writing a diary is easy enough. An insightful, thoughtful portrayal of a woman's surgical training, however, would be more welcome. Elizabeth Morgan leaves us waiting. □

CAPSULES

SOLO PRACTICE: A WOMAN SURGEON'S STORY, by Elizabeth Morgan, Little, Brown and Co., Boston, 1982.

Elizabeth Morgan's just-released second book, on the subject of her establishment of a private plastic surgery practice, is a strange document. It raises hopes similar to those raised by her first book (reviewed above)—hopes that Morgan will give us strong insight into what it is to be a woman and a surgeon—and the quotation on the back cover implies that inside we will find the drama of a crucial life decision. "I *had* to find a way to practice plastic surgery without ruining my life or neglecting my patients," the quotation concludes. "There must be a way."

Inside we do get the story of that decision, but in the baffling tone of an extended dinner conversation monologue, with all the attendant irrelevant asides. Morgan gives us a consultation here (on the potential complications of a facelift), a piece of folk wisdom there ("As women have known through the ages, the best person to nurse a mother back to health is her daughter . . ."), an endearing confession from nowhere ("It seems I have never arrived anywhere on time. I'm always exactly ten minutes late, yet it never fails to surprise me.")

If readers can look beyond the tone, however, they will find glimpses of serious issues: malpractice anxiety, money-hungry physicians, the workings of hospital administrations, professional backbiting, poor doctoring. There are also vivid descriptions of Morgan's cases sprinkled through the book.

It is harder to get a sense of Morgan's struggle to set up her practice. She tends to trust her reporting skills too much at crucial moments, giving her perspective a strange detachment. And her chattiness forms a smokescreen; it is difficult to get involved in why, for instance, she orders whiskey sours at fancy lunches (because restaurants tend to put very little alcohol in them).

One wonders about Morgan's motivation in writing this book. She circles the big topics and pounces on the little ones. The insight we hope for is bypassed in her rush to confide.

—LWD

VIVIENNE: THE LIFE AND SUICIDE OF AN ADOLESCENT GIRL, by John E. Mack and Holly Hickler, Little, Brown and Co., Boston, 1981.

This extraordinary case study of an adolescent suicide is the result of a collaboration between psychiatrist John Mack '55 and English teacher Holly Hickler, of the Cambridge School of Weston, Massachusetts. It began as an anthology of Vivienne's writing, assembled by her mother and Hickler during the two years following Vivienne's death. At that point John Mack, looking for samples of adolescent writing, contacted Hickler and read the manuscript. He was immediately impressed with it, and proposed the design of this book.

The result is a thorough, highly readable investigation of Vivienne's life and suicide, organized in a way which avoids facile conclusions. The first half relies heavily on the girl's writing—poetry, letters, journal entries, and schoolwork—and on recollections from members of her family, to explore her feelings and struggles. Mack then offers "A Clinician's Analysis," which considers Vivienne's death in light of the rapidly growing phenomenon of adolescent suicide, and offers suggestions for the prevention of such tragedies. The book concludes with "A Teacher's Viewpoint," from Hickler, on the role of teachers in the adolescent's world.

In allowing Vivienne's story to remain closely tied to the evidence she herself offered, Mack and Hickler involve the reader in looking for answers to the natural questions posed by a suicide. Their essays then corroborate our conclusions, raise new questions, and offer food for thought.

Suicide now vies only with accidents as the major cause of death in the fifteen-to-nineteen age group. As in the very best of case studies, this close examination of a single victim serves to illuminate a whole phenomenon.

—LWD

CONFESSIONS OF A KNIFE, by Richard Selzer, Simon and Schuster, New York, 1981.

In these 23 short fiction explorations of the enigmatic and bizarre, Richard Selzer neatly exploits his dual role as surgeon and writer. His medical knowledge widens his capacity for metaphor, and narrows his perspective more precisely to the point: we move through a language as evocative as painting.

We are told that the language of pain has no consonants; it is a sound made entirely of vowels. We are made to believe that the doctor's experience is that of a world traveler, moving through space and time. And in that world there is nothing more important than our humanness, than the surgeon saving a man's life, than the life of the man who is saved on the table.

Selzer's approach is epic: he takes pleasure in recalling world mythology and literature. He reaches back into history and across the continents in stories such as "The Spoils of Troy," "Sarcophagus," and "Four Appointments With the Discus Thrower." He takes us to the opera, the Rhineland, and the Sinai Desert.

In the end this collection is exactly what it purports to be: confessions of a man who is also a surgeon, and whose attentiveness to words appears synonymous with his attempts at care-giving. "I stand in the doorways of hospital rooms and gaze," he confides. "Ought not a doctor to observe his patients by any means and from any stance, that he might the more fully assemble the evidence?"

—DSG

SECOND LIFE, by Stephani Cook, Simon and Schuster, New York, 1981.

After a hysterectomy, open heart surgery, and many months of throwing pulmonary emboli, former model Stephani Cook was diagnosed as having had a metastasizing cancer for two years. She underwent chemotherapy and survived. In *Second Life* Cook has written a compelling page-turner—a book worth losing sleep over—about her years of illness and their effect on her personal life.

Her approach avoids sentimentality, heading unerringly for the emotional center of her experience as a patient. "I hadn't counted on blood," she writes of her reaction to an angiogram. "I hadn't counted on stitches like cat whiskers, and the humiliation of a mouth open, a tongue protruding in mute agony, a body arched and open as if in the crippling throes of a passion, while strangers looked on and took measure of me with these intimacies. I hadn't foreseen being violated, or having people know me as I was unlikely ever to know myself."

This ability to articulate the emotional truth of her story, in addition to the vividness of her descriptions, makes Cook's account one of the most eloquent in that growing genre of books by survivors of life-threatening illnesses.

—LWD

Making doctors tough

At the age of 34, Charles LeBaron—published novelist and sometime social worker—entered Harvard Medical School, seeking a "revenge of gentleness" for all the victims of uncaring and incompetent medical care he had known. Now he describes his experiences in "a vivid report from the front lines... dramatic and amusing."

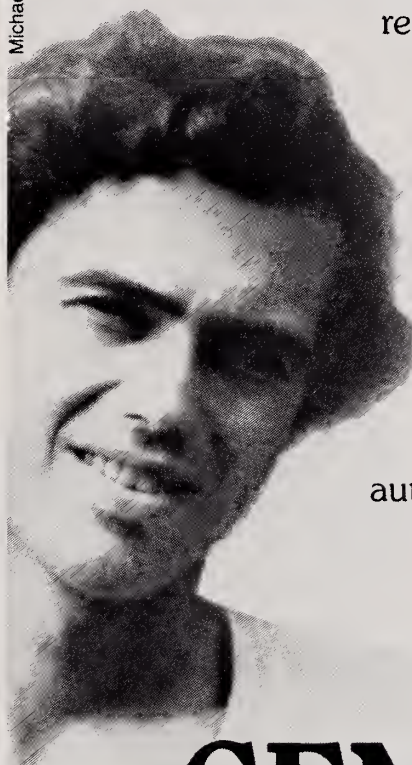
—New York Times

"A tough, touching, shocking, and ultimately exhilarating peek at the unwitting brutality and rare inspiration served up in the first year at one of the best medical schools in America."

—Samuel Shem, M.D., author of *The House of God*

"A classic of its kind."
—Boston Globe

Michael Raab



GENTLE VENGEANCE

An Account of the First Year at Harvard Medical School

by Charles LeBaron

\$4.95 Penguin Paperback

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Bicentennial Preview

The Harvard Medical School Bicentennial year will run from June 1982 to June 1983, beginning and ending with Alumni Day and Class Day activities. Our theme is "Learning and Caring," and the emphasis will be a celebration of the contributions which biomedical science and health care have made to human life. The principal events in Boston will be:

Alumni Week	June 8-11, 1982
Academic Convocation	October 11-14, 1982
Alumni Week	June 8-10, 1983

In addition, there will be programs at the affiliated hospitals and regional programs in various sections of the country. We hope that all alumni of HMS will renew their association with the School in the course of this year.

Bicentennial Academic Convocation Week

October 11-14, 1982

Scientific Symposia October 11-13

Atherosclerosis/Cardiovascular Disease

Dr. W. Gerald Austen, Moderator

- Atherogenesis
Dr. Joseph L. Goldstein
- Thrombosis
Dr. John R. Vane
- Hypertension
Dr. Edgar Haber
- Coronary Artery Disease
Dr. Eugene Braunwald

Biologic Determinants of Behavior

Dr. Seymour Kety, Moderator

- Neurohumoral Peptides
Dr. Hans Kosterlitz

- Brain Metabolism
Dr. Louis Sokoloff
- Aplysia
Dr. Eric R. Kandel
- The Sensory System
Dr. Vernon B. Mountcastle

Cellular Neurobiology

Dr. Torsten Wiesel, Moderator

- Neurogenesis
Dr. Viktor Hamburger
- Cell Death
Dr. W. Max Cowan
- Synaptic Network Formation
Dr. David Hubel
- Role of Slow Viruses
Dr. D. Carelton Gajdusek

Genetics

Dr. Philip Leder, Moderator

- Gene Structure
Dr. Walter Gilbert
- Developmental Genetics
Dr. Donald D. Brown
- Gene Manipulation
Dr. Frank Ruddle
- Human Disease
Dr. Yuet Wai Kan

Hormones and Metabolism

Dr. John Potts, Moderator

- Secretion of Proteins
Dr. David D. Sabatini
- Insulin Receptors
Dr. Jesse Roth
- Steroid Receptors
Dr. Bert W. O'Malley
- Hormone Resistance
Dr. Jean D. Wilson

Immune Response

Dr. Baruj Benacerraf, Moderator

- Immunoglobulin Genetics
Dr. Hugh McDewitt
- T-Cell Specificity
Dr. William E. Paul

- Regulatory Circuits
Dr. Hans Wigzell
- Immune Regulation
Dr. Stuart F. Schlossman

Inflammation

Dr. K. Frank Austen, Moderator

- Complement Pathways
Dr. Hans J. Muller-Eberhard
- Lymphokines and Monokines
Dr. Zanvil A. Cohn
- Chemical Mediators
Dr. Bengt I. Samuelsson
- Phagocytosis
Dr. Thomas P. Stossel

Malignancy

Dr. Howard Green, Moderator

- Cell Biology
Dr. John Cairns
- Tumor Viruses
Dr. David Baltimore
- Chemical Carcinogens
Dr. Elizabeth C. Miller
- Hormone Receptors
Dr. Elwood Jensen

Medicine and the World: Challenges of the Future

Dr. David A. Hamburg, Moderator

- Worldwide Perspective
Dr. Adetokunbo O. Lucas
- Scientific Approaches
Dr. Sune Bergstrom
- Social Approaches
Dr. John R. Evans
- Public Health Approaches
Dr. Halfdan Mahler

Academic Convocation

October 14, 10:00 A.M.

- Academic Procession
- Addresses
- Presentation of awards and honorary degrees

Alumni Week June 8-11, 1982

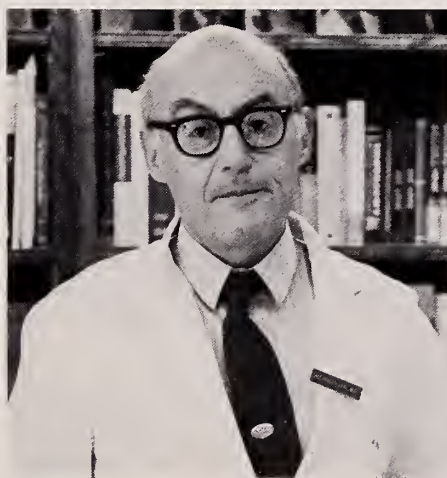
	Tuesday, June 8	Wednesday, June 9	Thursday, June 10	Friday, June 11
MORNING	Retrospective planned by the Class of 1932	9:00 Opening Ceremony of the HMS Bicentennial 9:30 Symposium: Financing Health Care • Health Insurance • Freedom of Choice • Competition Strategy	Historical perspectives on HMS Faculty Scientific Symposium	Commencement Alumni Day Program and 88th Annual Meeting of the Harvard Medical Alumni Association
	Luncheon	Luncheon	Luncheon	Luncheon
AFTERNOON	(continuation of) Class of 1932 Program	Symposium: Forms of Practice • Solo • Group • HMO • Academic	Class Day Class of 1957 Scientific Symposium	Activities of Reunion Classes
		Garden Party on the HMS Quadrangle		
EVENING	Dinner at Boston's Museum of Science Lewis Thomas, <i>guest speaker</i>	Boston Pops Concert Symphony Hall	Reunion Class Parties	

Nuclear War Course Formed

Experts agree that the medical capacity of an entire nation would be severely strained—if not overwhelmed—by efforts to treat the victims of a single nuclear attack; and the estimated twenty percent of physicians who would remain alive in the aftermath would have little to offer millions of critically wounded survivors. The new course at HMS on "Health Effects of Nuclear Weapons and War" will address such post-war medical problems as burns, trauma, and radiation, but its underlying theme is better reflected in the official title: Prevention 709.

On February 4 in Amphitheatre E, a capacity audience turned out for the first meeting of the course, which included a seldom-shown film on Hiroshima after the bombing, as well as a presentation by Thomas Halsted, Director of the antinuclear group, Physicians for Social Responsibility (PSR). Halsted spoke on the variety and capability of hardware now available (more than a million times the nuclear potential of the bomb dropped at Hiroshima, or five tons of explosive power for every man, woman, and child on earth).

Prevention 709 was inspired, in part, by the first Congress of International Physicians for the Prevention of Nuclear War (IPPNW), held in March, 1980 in Airlie, Virginia and attended by more than 100 doctors from the U.S. and abroad. Soon after the Congress, members of the HMS students' Nuclear



Dr. Leaf

War Study Group formally requested that instruction in this topic be included in the medical school curriculum. Interested members of the faculty developed the course, which is being offered as an elective under the auspices of the Department of Preventive Medicine and Clinical Epidemiology.

Alexander Leaf, the Jackson Professor and chairman of that department, explained the rationale for including this material in the medical school curriculum: "Since society delegates to the medical profession an important role in preserving and improving the health of its citizens, physicians-in-training should receive instruction in the health consequences of the use of nuclear weapons. Fortified with available facts, the medical profession can best determine its role, if any, in the care of survivors of

a nuclear war, or alternatively, in the prevention of its occurrence."

Course material will include the physics and delivery of weapons systems; the biological and ecological effects of radiation, blast, and intense heat; post-attack medical and psychosocial needs and likely remaining medical resources; the psychosocial implications of living under the continual threat of nuclear annihilation; and the international psychology supporting the arms race. Lecturers will include Leaf, Everett Mendelsohn, Herbert Abrams, John Constable '52, Samuel Latt, John Mack '55, James E. Muller, and John Kenneth Galbraith (all of Harvard), Kosta Tsipis, Henry Kendall, and Eric Chivian '68 (all of MIT).

The course represents one facet of a widening movement among physicians and medical students to "get the facts to the people, so there can be an intelligent and informed national policy," explained Bernard Lown of the School of Public Health, president and founder of IPPNW. This organization and PSR have been instrumental in bringing together members of the medical community in sessions aimed at education and public policy. Last December, the American Medical Association passed a recommendation calling on doctors to "prepare appropriate informational materials to educate the physician population and the public on the medical consequences of nuclear war." Both the World Health Organization and the Institutes of Medicine have expressed similar concerns. □

Darsee Report Issued

In January Dean Daniel C. Tosteson issued a twelve-page report compiled by an *ad hoc* committee* he appointed last November to investigate allegations that John R. Darsee, a former research fellow in the Brigham and Women's Hospital Department of Medicine had fabricated experimental data. The committee was also asked to evaluate the way in which the University handled the matter and to recommend procedures for dealing with similar situations should they arise in the future.

"Dishonesty in research strikes at the very heart of true science; it is a contradiction in terms," Tosteson said when he released the report, which is divided into five sections:

- I. *Chronology of Events*
- II. *Summary of Evidence*

- III. *Institutional Response*
- IV. *Prevention of Dishonesty in Science*
- V. *Recommendations to the Harvard Medical School*

Copies of the entire report are available upon request from the *Alumni Bulletin* office.

*Committee members: Richard S. Ross, Dean of the Faculty and Vice Chairman for Medicine at Johns Hopkins (Chairman); A. Clifford Barger, Professor of Physiology, HMS; Baruj Benacerraf, Professor of Comparative Pathology, HMS, and President of the Sidney Farber Cancer Institute; Burton S. Dreben, Professor of Philosophy at Harvard; Saul J. Farber, Professor of Internal Medicine and Chairman of the Department at New York University; Gerald Frug, Professor of Law at Harvard; Robert I. Levy, Dean of Tufts University School of Medicine; and Joseph B. Martin, Professor of Neurology, HMS.

An Open Letter to HMS Alumni

As representatives of the first year class at HMS, we are writing to you concerning the substance of President Reagan's budget recommendations to Congress, the effect of these proposals on medical students in general and HMS students in particular, and steps that can be taken to avert the impending crisis.

The accompanying chart summarizes the bleak situation facing medical students should a new Continuing Budget Resolution be approved by Congress on March 31, 1982:

At a time when (1) medical school tuition has increased greatly due both to the phasing out of federal capitation payments and inflation and (2) medical student indebtedness upon graduation has increased by more than 300% in ten years, President Reagan proposes that HEAL and Auxiliary Loans to Assist Students (appropriately abbreviated ALAS) supplant GSL as the major loan program for health professions students. While GSL offers a \$5,000 annual maximum at 9% interest and government payment of interest while in school, HEAL "offers" a maximum of \$15,000 per year at a current rate of 19.5% (treasury rate plus 3.5%) with interest accrual during the years of undergraduate medical education.

If one were to borrow \$8,000 per year under HEAL at 19.5% interest for four years (a principal of \$32,000), one would end up paying \$2,215 monthly for 15 years or a total of \$398,700! With a somewhat more favorable interest rate, ALAS as proposed would provide up to \$8,000 annually at 14% without the benefit of federal interest subsidies for in-school periods. (Currently, ALAS is only operational in 14 states and possesses an annual limit of \$3,000.) It has been estimated that graduate student indebtedness would increase by as much as 67% under ALAS.

Richard W. Black, coordinator of financial aid for Harvard University, is quoted as saying, "I'm very scared," about the proposal to eliminate GSL for graduate students. We are also very concerned about the impact that this Administration's policies will have on the future character of American medicine. At HMS two-thirds of financial aid is derived from federal programs and tuition for the 1982-1983 academic year has been set at \$10,235, 15% higher than last year's figure. Sheer economics will tend to discourage students from middle and lower income families from applying to medical school. "New" physicians will be directed away from primary

Second Year Show

The Precynical Years, clockwise from top left: "Upper East Side Story" (Nadine Muscatel and Ed Hundert); "I Wonder Why" (Stu Frank); "Fam"

(Nancy Newman, Jeff Berman, Ken Freedberg, Cato Laurencin); "Anatomy Lab's Alright for Slicing" (Michael Longaker).



Program	President's Recommendation	This Program as a Percentage of 81-82 HMS Financial Aid	Recipients as a Percentage of Total HMS Students
Guaranteed Student Loan (GSL/FISL)	Eliminate* Grad/Professional students entirely	48% (also 48% of <i>all</i> medical school financial aid)	100% (72% of <i>all</i> medical students nationally)
Health Professions Student Loan (HPSL)	\$0	5%	29%
Exceptional Financial Need Scholarship	\$0	.8%	
National Direct Student Loan (NDSL)	\$0	.6%	7%
Health Education Assistance Loan (HEAL)	\$80,000,000**	11%	65%
College Work-Study Program	\$400,000,000 (a 27% reduction from FY82)	2%	
National Health Service Corps Scholarship (NHSC)	No new scholarships. Continuing awards only, leading to phase out.		

*The Federal Government spent the relatively trivial amount of \$2.6 billion on GSL in 1981, a figure which includes both graduate and undergraduate populations.

**This level of HEAL will be insufficient to replace the borrowing lost to health professions students by elimination of the other Federal loan programs.

care in rural and inner city areas by the financial pressures of loan repayments. The costs to consumers of health care will rise concomitantly as physicians seek to repay astronomical debts. Those inclined toward academic medicine, and the basic science and clinical research upon which medical progress depends will be forced to carefully reconsider these potentially less remunerative careers.

While the mood of HMS students is currently one of great concern and apprehension, we are also confident that pressure can be brought to bear on Congress to preserve higher education loans in meaningful form. Out of this conviction 15 HMS students have descended on Washington for an intensive day of lobbying along with other graduate and professional school students from across the country. We ask that you join with us in our efforts by contacting your congresspersons and senators and mobilizing local and national professional medical societies to undertake supportive lobbying measures.

Thank you very much for your consideration of this vital matter.

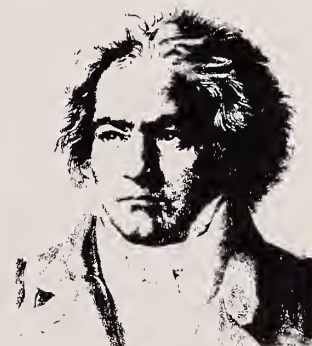
**Lewis M. Milrod
Jose Rivas
Stephen D. Zucker**

Hear the Harvard-Radcliffe Orchestra, with the massed choral forces of the University, present Beethoven's Ninth and Schoenberg's *Survivor from Warsaw* at Symphony Hall

America's oldest musical organization closes its 175th season with a special benefit concert at Symphony Hall at 8 p.m. on Friday, April 30. The program will begin with Arnold Schoenberg's *A Survivor from Warsaw* and conclude with Beethoven's Ninth Symphony.

In keeping with the themes of human freedom and kinship expressed in these works, the concert will honor Amnesty International on the occasion of its 20th anniversary.

Joining the HRO in this landmark concert are the Harvard Glee Club, the Harvard-Radcliffe Collegium Musicum, the Radcliffe Choral Society, and distinguished soloists: Lucy Shelton, soprano; Milagro Vargas, contralto; Charles Walker, tenor; and Keith Kibler, bass. James Yannatos will conduct. The narrator for *A Survivor from Warsaw* will be United States Senator Paul Tsongas.



Seats are priced at \$15, \$10, and \$6, with reductions for students, groups, and senior citizens. Available at the Holyoke Center Ticket Office, Bostix at Faneuil Hall, and Symphony Hall box office. Call 617-498-6249 to arrange group rates.

Contributions to the Harvard Pierian Foundation, Inc., are tax-deductible.

Medicine's Nonordinary Reality

by Peter Rintels '83

...these hallucinogens produced in me...some peculiar states of...altered consciousness, which I have called "states of nonordinary reality." I have used the word reality because it was a major premise in don Juan's system of beliefs that [these] states of consciousness...were not hallucinations, but concrete, although unordinary, aspects of the reality of everyday life.

Carlos Castaneda, *A Separate Reality: Further Conversations with don Juan*

During my three months as a clerk on internal medicine I hallucinated only once. It was 11:00 p.m. following a sleepless night on call: while trying to dash off my last progress note, I noticed that a sentence which began with a description of a patient's breathing problems ended with something about a train ride. Then my pen dribbled off the end of the page. The rest of medicine, I'm fairly sure, was concrete reality, but very little of it would I label "ordinary." In the fourth of Carlos Castaneda's books, the Indian sage don Juan reveals that hallucinogens are not really necessary for experiencing "nonordinary reality." In my third year of medical school, the wards taught me the same lesson.

Medicine being my first rotation, there was a great deal of the "shock of the new" (to borrow a phrase) which contributed to a sense of otherworldliness. But newness was not the crux of this sense; rather it was a feeling of disorientation and outright absurdity—of everyday thoughts taking on uncertain meanings. Castaneda speaks of experiencing the "condition of inapplicability," which entails "the cessation of the pertinence of my world view." "Inapplicability" is being asked, after a very likeable patient was discovered (as an incidental lab finding) to have an untreatable leukemia, "So Peter, are you enjoying medicine?"

The language of medicine, both formal and informal, helps establish it as a world apart. On the wards I found



familiar Anglo-Saxon words like "sweating," "nosebleed" and "gallstone" elbowed out of my vocabulary in favor of their tongue-knotting Greek equivalents: "diaphoresis," "epistaxis" and "cholelithiasis." And patients inexplicably gave up "walking" for "ambulation."

In part this language is used for precision and convenience ("orthopnea," for example, is not easily replaceable by anything more straightforward). But a case can also be made that the language is a reflection of the scientific values of medicine, values which sometimes coexist uncomfortably with its humanistic ones. Sociologist Alfred Schutz, in an essay titled "On Multiple Realities," explains experience as "finite provinces of meaning." We assign different meanings, for example, to what we perceive in dreams and in waking reality. The "world of everyday life" is one such province, Schutz holds. Science is another, set apart by its suspension of common emotional concerns, most notably what he calls the everyday world's "fundamental anxiety"—the fear of death.

Schutz's essay recalls the comment of Sandor Ferenczi, the great disciple of Freud, that "Pure intelligence is thus a product of dying, or at least of becoming mentally insensitive..." Psycho-

analysis also contributes the unsettling insight that the impulse toward scientific mastery has its roots in the anal-sadistic phase of libidinal development—which perhaps explains why, according to a friend of mine, a surgical intern commonly referred to his patients as "stool."

The peculiar detachment of the scientific province of meaning from everyday concerns accounts for one of the most surreal aspects of ward life—the way people can regale each other with stories of discovering medical disasters. An intern I worked under was fond of recounting how he had one-upped a particularly reviled private physician by ordering a skull CT scan on a patient who the private physician insisted could not have a brain tumor. Sure enough, the scan showed a "gumba" and he described in delighted detail the physician's stunned, silent and presumably embarrassed reaction.

To a patient, who approaches medicine with everyday concerns of life, death and suffering, the discovery of a brain tumor is perhaps the ultimate in terrifying medical news. Yet in the scientific province of meaning, such information becomes mere data. I felt oddly bewildered at how the concerns of the world I had known almost exclusively until July, when I started Medicine, could somehow seem so distant.

Death takes on a vaguely unreal quality in this atmosphere. The first time a patient I knew died, the experience had a Camus-like quality, like the opening line of *The Stranger*: "Mr. Walker died today, or was it yesterday?" The coronary care unit team discussed his death at rounds the next morning, questioning what may have gone wrong and what we might have done differently—nothing it turned out. The team was briefly sad and mournful, but we were soon on to the next case, and the empty bed was quickly filled by another owner of a sick heart. I had somehow expected death to be a bigger deal. I assigned this episode to the "Welcome to the world of medicine" category, leaving it to later

to puzzle out exactly what I meant by that.

Physicians must mediate the inevitable tension between scientific and everyday meanings in a way that no other professionals have to. In medical parlance, a patient may "present with pain." In the real world, however, people hurt. Medicine demands that we speak of urine and feces with the detached attitude of people searching for clues to a scientific puzzle, oblivious to how in everyday life these things disgust us.

There is a second language of the wards, the informal, sometimes almost whimsical banter of the housestaff. "Buff" and "turf" (familiar to *House of God* readers) are part of it. A patient might also "box" ("He boxed in the ambulance" = "He didn't make it."), "crump" (deteriorate badly), or have single or multiple "gumbas" (tumors, usually). A couple of residents were fond of asking, "What's he sportin'?" for "What's wrong with him?" Probably oddest of all is "dying with Harvard numbers" or "dying a Harvard death" (accomplished when, thanks to the laborious efforts of the housestaff to give a patient perfect laboratory values, there appears to be nothing wrong with him except for the fact that he is dead).

The housestaff language contributed to another facet of the surreal quality of medicine. At times there was an almost magical atmosphere on the wards that defied gravity. A confounding levity can reign in the face of the most horrendous tragedies. Not only I, but classmates I have spoken with as well, laughed at things that made us feel guilty on reflection.

I could recount, with some embarrassment, many anecdotes to illustrate the peculiar character of what can seem funny in medicine, but it was the hatman who set the standard. The hatman was so named because he came into the Beth Israel Hospital Emergency Room with a greasy pork pie hat and insisted on wearing it after, and sometimes during, the five or so physical exams he underwent—no matter how much of the rest of his clothing we insisted he remove. He was a gaunt, elderly man with a thinned, grey beard. He spoke with a sing-song Yiddish accent, which for all its charm was not entirely penetrable.

On this July day he lay on an ER stretcher in thermal underwear, covered by a sheet, topped off by his beat-up hat like a sundae with a cherry. The resident on duty, who had a hip counterculture breeziness that added to most comic ER situations, asked him, "Hey man, are you a rabbi?" and Hatman convincingly answered, "No, I am a prophet."

Hatman had fallen at home and was experiencing severe leg pain. Successive examiners tried mapping the pain by touching various areas and listening for the response. It was less of a procedure than a game. In his sing-song accent, he responded by saying either "pain" or "no pain," or, if a particularly sensitive area was touched, he let out a rapid burst of "pain, pain, pain, pain!"

It did me in. For reasons which, on reflection, I still cannot completely understand, watching this procedure left me in such spasms of laughter that I had to leave the room. Hatman gave a theater-of-the-absurd quality to the medical routine: I half expected the next ER patients to require treatment for

*The language of medicine
helps establish it as a
world apart. Patients
inexplicably gave up
"walking" for
"ambulation."*

having turned into rhinoceroses. And while Hatman's leg problems received the serious medical attention they needed, my image of medicine as an ultimately serious world was dealt a hefty blow.

I found the seriousness of the profession also challenged by a certain class of patients, the so-called "gomers," in whom the tragedy and comedy of medicine meet like a head-on train wreck. Demented or comatose, the gomer lacks the sense of personhood (or incipient personhood of, say, an infant) that allows caregivers to feel they are helping a real human being.

For me, the approach was more often one of demoralizing frustration, a feeling of being straitjacketed by the everyday world's "province of meaning" which too easily identifies life and death with good and bad. During my first week in the BI's CCU, a nurse taking care of a comatose patient who had no real chance of recovery pulled me aside to say, "Peter, when you become a doctor, please don't keep dead people alive."

Out of the frustration can rise a sense of comic absurdity, that for all of the lofty ideals we bring to medicine, a kind of joke is being played on us. In an analysis of Zen, M. Conrad Hyers has written, "Our experience of irrationality, meaninglessness and chaos are deeply tragic. Yet absurdity is also at the heart of comic awareness." This is not to say that "gomers" are not tragic, but is an effort to explain cracks about the "positive Q sign" (shown by patients whose tongues hang out of their mouths) or why once on morning rounds an intern kidded around with a comatose stroke patient.

That incident had the "what-a-waste-of-time-this-is" quality that characterizes a lot of housestaff interaction with the worst-off patients, especially the gomers. Our team was later appropriately blasted by the head nurse on rounds. "We treat our patients with respect on six north," she said, and glaring at a withering medical student added, "and we never laugh in patients' rooms."

But we do. Why? Freud offers: "There is no doubt that the essence of humor is that one spares oneself the affects to which the situation would naturally give rise and overrides with a jest the possibility of such an emotional display. . . . [Humor's] meaning is: 'Look here! This is all that this seemingly dangerous world amounts to. Child's play—the very thing to jest about.'"

Surely ward humor is in part defense. One is brought face to face with the compelling evidence of human fragility and mortality that cannot but heighten the "fundamental anxiety" of death and suffering. One is faced with impossible demands, the inevitability of mistakes and, especially as a third-year student, doing foolish things. Humor unshoulders an emotional burden. Amusing stories get told in the ER. A simple defense: call a man a "dirtball" and you don't have to worry about what it is really like to be crazy and to have to sleep in the gutters.

During my three-month medicine clerkship, "nonordinariness" intruded into my experience so often, both in what I saw and in my own reaction to it, that, for me at least, it became the unifying theme of the course.

Don Juan routinely makes Castaneda appear foolish for the way he tries to make sense of his experience of "nonordinary reality," and perhaps this is in the cards for me as well. In any event, as don Juan implies, to truly understand any reality, one must strive to see it simultaneously from many points of view. Certainly humane medicine demands this ability. □

Ground Rounds, or Scrubbing in at the BCS

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30 HUNTINGTON AVENUE, BOSTON

SUMMER COURSE

JULY 11 TO AUGUST 15, 1906

Two sessions each week-day, Saturdays excepted

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Ten lectures.

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Infant and Child Feeding

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Applied Organic Chemistry

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Ten Practice Lessons

FANNIE MERRITT FARMER

Feeding in Institutions

Four Lectures

ALICE BRADLEY

Duties of a Waitress

Eight Practice Lessons

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Marketing Course

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Advanced Cookery

Twenty Practice Lessons

FANNIE MERRITT FARMER

ALICE BRADLEY

Mrs. C. E. PEARCE

DEMONSTRATIONS

Four Lectures

FANNIE MERRITT FARMER

FANNIE MERRITT FARMER



TERMS, \$40
PROSPECTUS SENT ON APPLICATION

Once upon a time, Harvard Medical students took cooking classes. Specifically, from 1881 to 1899, HMS IV's attended a month of lessons at the Boston Cooking School, run by Fannie Farmer, to learn how to prepare such dishes as clam frappé, silver lady fingers, and hot cereal with fruit.

In 1894 New England Kitchen Magazine wrote of the BCS's special instruction: "Classes from the City, Massachusetts General, Homeopathic, McLean, and Concord, N.H., hospitals are taught the hygiene and methods of sickroom cookery. . . For years Harvard Medical School has sent a class of students to be taught to prepare nourishing and tempting food for invalids. This year there are two full classes from that institution."

Although the HMS classes at the BCS were discontinued in 1900, Miss Farmer herself continued to lecture Harvard Medical students, and went on to collaborate with Elliott P. Joslin on developing diets for diabetics. Joslin

later credited her with giving him "the stimulus which started me writing about diabetes."

Reprinted here are excerpts from a New England Kitchen Magazine article, also published in 1894, by Carrie M. Dearborn, of the BCS. Titled "The Therapeutics of Diet: The Doctors' Course at the Boston Cooking School," it describes the nature of, and reasoning behind, the Doctors' Course.

A diet suitable for people who are well and strong is one thing, and a diet adjusted to the needs of invalids and convalescents is quite another.

Several years' experience in teaching the art of cookery as adapted to different classes of people has brought to my notice the increasing importance which all progressive medical men attach to the value of proper diet in the sick room.

Medical journals no longer confine themselves to treatises on *materia medica* and surgery, but gladly welcome

to their pages all contributions from authoritative sources on the proper preparation of foods for invalids.

We must not think of therapeutics as relating to drugs only; it should be considered in a broader sense. There is a curative power in fresh air, sunshine, exercise, clothing and, most of all, in the food we eat.

The best physicians of the present day believe thoroughly in a scientific diet, and say that its importance can not be over-estimated in the treatment of disease. The consideration of food, not as opposed to drugs but in conjunction with them, is of inestimable value in the restoration to health, and it is imperatively necessary in order to be a successful nurse or medical practitioner, that one should have more than a superficial knowledge of the chemical constituents of foods and the results produced by the different processes of cooking.

In days past a physician's knowledge on this subject was too often em-

bodied in the oft repeated formula, "Give the patient plenty of milk and beef tea (be sure to strain the latter), and he may have a soft-boiled egg once a day." Or, to a dyspeptic individual: "Drop at once the use of coffee, eat no pork nor hot bread and you'll be all right." And indeed, within a very short time I have known of *blanc mange* being allowed a patient by a physician who was at the same time prohibiting the use of starches in his diet. Could this doctor have realized that to the ordinary housewife *blanc mange* meant but one thing, namely, the use of corn-starch cooked in milk until of the desired consistency and then cooled?

Certainly he could not have considered that the average cook knows too little of the scientific preparation of food for invalids to be able to discriminate between an almost raw preparation of starch, totally unfit for the case in hand, and the harmless but nourishing dessert made from Irish moss and likewise called *blanc mange*...

Too often does the anxious and loving but, on this point, uneducated mother or housekeeper undo or retard the action of the proper medicines by the unwise administration of foods which the patient fretfully insists are the only ones for which he has the slightest appetite. Or, some "progressive" woman thinks she knows it all because she has faithfully studied her book of directions, bought in conjunction with a home case of medicines; and while she is giving aconite or something similar to reduce feverish symptoms, she also urges the patient to partake freely of toast, or at least of gruel, not for a moment realizing that starchy food is never well digested in febrile conditions because the secretion of saliva upon which the digestion of these foods so much depends is always more scanty in such cases.

In certain nervous diseases the consumption of tea, coffee or other stimulating food may completely overbalance the desired effect of sedative medicines; and in many cases of intestinal inactivity are not more fluids and coarse foods as necessary, and perhaps better than the use of aloe or other purgatives which only give temporary relief and tend to render the pathological condition permanent?

If one has the privilege or inclination to read the most advanced medical journals of the day, he will find an ever increasing interest in the subject of diet. This is now considered of as great importance as the administration of drugs or the outward care of the body. Most of the popular training schools for nurses include a course in the preparation of foods for invalids and convales-

CLAM FRAPPE. — Wash thoroughly twenty clams and put them in a stew pan with half a cup of cold water; cover closely and steam until the shells open. Strain the liquid, cool and freeze to a mush. Serve in glasses. A small amount may be frozen easily in a baking-powder can, by setting it in a tin pail and packing with ice and salt in equal proportions. The mixture will freeze in about half an hour and should be stirred once or twice during that time. This clam juice is also very often diluted and served hot, and in some cases of gastric inflammation will be retained by the stomach when almost everything else is rejected.

EGGS IN BATTER. — Mix two tablespoonfuls of thick cream with one tablespoonful of stale bread crumbs (which have been sifted through a coarse strainer to remove the large bits) and half a tablespoonful of salt. Butter a little shirring dish, put in a teaspoonful of the mixture, then a raw egg; season with salt and a few grains of white pepper and cover with the rest of the moistened crumbs. Set the little dish in a small tin of hot water in the oven and bake for eight minutes; then serve at once. The hot water is to keep the egg from baking too rapidly, and when properly cooked the batter will be creamy and delicate, not even the white being hard and firm.

The little slips of toast should be cut thin, from stale bread, and toasted slowly (not burned) to evaporate all the moisture.

cents in their curriculum, and the medical departments of universities and colleges already include an elective course in this important branch of study...

Possibly it may interest those who have not previously had their attention drawn to the subject, to know what such a course of study includes. Having a more intimate knowledge of the course as given by the Boston Cooking School and by graduates of its training classes who now occupy positions as instructors in hospitals elsewhere, we will take its course of study as probably the best example yet developed, of the training in this line now considered so essential to both physicians and nurses. This course may be extended through a three months' term, or condensed to not less than six lessons.

The first lessons of the course are devoted to the preparation of the various dishes included in the so-called liquid diet: peptonized milk, beef teas,

and extracts, gruels, etc. These are succeeded by the different beverages and demulcent drinks, jellies, breakfast cereals, toast and eggs in various ways, oysters, broths, steaks, chops and simple vegetables, cooked fruits and delicate desserts which include the making of custards, fruits, ices, ice-cream, etc.

I have used the word lessons in speaking of the instruction particularly, because practice lessons are considered so much more beneficial to the pupil than demonstration lectures by the teachers. In this, as in many other things in life, the real practical experience gained by doing rather than by seeing done, is found to be of the most lasting benefit; and a physician who has once made beef tea with his own hands or cut up a chicken for a broth, will be better able to direct its preparation for a patient. Every bit of the cooking is done by the pupils under the supervision of the teacher, and at the end of the course both doctors and nurses often say, "The shortness of the course is simply an aggravation; we wish it were twice as long."

This year the "doctors' classes" at the Boston Cooking School have been more fully attended than usual, which goes to show, as their attendance is not obligatory, that the interest in this subject among medical men is continually increasing.

A very interesting public demonstration lecture on foods for invalids and convalescents, with artistically arranged trays of dainty dishes, was given recently at the school by the Principal, Miss Farmer, and her assistant Miss Wills. The *menu* included dishes suitable for a convalescent's breakfast and dinner, and as some of them are quite novel I will append the recipes used. Cereal with fruit, eggs in batter and cocoa with dry toast was served for the breakfast, while clam frappé, cream of halibut soup, sweet breads *en coquille*, apricot and wine jelly with silver lady fingers would almost make one willing to be just a little ill if he could be treated so royally.

The method of serving and arranging ever so simple a repast is considered an essential in the care of the sick and much attention is given to this as well as to the methods of cooking.

Trifles assume tremendous proportions when one is ailing, and as much attention should be given to the serving of foods as to the administration of medicines. □

The Bulletin thanks Laura Shapiro, who is writing a book on women and cooking at the turn of the century, for her research assistance.

Adaptation of a Lecture

When Doctors Fail to Care for Themselves

by George E. Vaillant

Psychiatry 700.A (Behavioral Science in Medicine) is a course designed to sensitize medical students to the importance of self-awareness, and to decrease the distance between them and the patients they see. Last fall the concluding lecture in this course was given by George E. Vaillant '58, who outlined defense mechanisms used by physicians, as well as the risks of those mechanisms. He also asked for students' thoughts on the hazards of their chosen profession, and, in a room charged with energy, elicited the responses highlighted on page 21.

*Vaillant is Professor of Psychiatry, and Director of the Grant Study, an ongoing longitudinal study from which he drew material for his book *Adaptation to Life*. Originated in 1937 by Arlie V. Bock as "a systematic inquiry into the kinds of people who are well and do well," the project has followed the lives of 268 men, selected when they were in college, to their sixth decade. Vaillant recently completed a book to be published by Harvard University Press, *The Natural History of Alcoholism: A Thirty-Five Year Prospective Study*.*

Today, to pull together the six sections of this course, I need to synthesize aggression, drinking, drug abuse, anxiety, inheritance, and attachment. I'm going to do it the way a lot of teaching and learning is done in medical school: each upon each—as our laboratory diagnosis teacher used to say. That's how you pass your first nasogastric tube, and how you draw your first blood. So today I'm going to demonstrate the relevance to doctors, to you, of what you've been learning.

One purpose of a psychiatry course in medical school is to teach you to be wise and to have as much sense about human affairs as your grandparents: to grow old before your time. What you're really trying to learn from psychiatry, then, is to be rational in the face of irrational feelings and behavior—in the face of unreason.

I'd like to introduce you to the relevance of such unreason with two recent letters from members of the Har-



vard Medical School class of '67 to the *Alumni Bulletin*:

"It is an immensely sobering and painful thought to realize that out of my medical school class—a cohort of people in their late thirties—we have already lost six of our members, two through acts of God, one uncertain, and three quite definitely by their own hands. I

fear that this is no more than one of the painful realities of life in an unbelievably demanding profession. Yet, I feel that we do not—as a group or profession—pay sufficient attention to this factor in our lives. It provokes large numbers of reflections concerning mortality, stress, and the ability to help our colleagues when they need it, and similarly unseasonal but powerful reflections."

The other letter observes: "The tragic death of John brings to six the members of my class who have died. Five have died at least in part because of maladaptive lifestyles. This death rate seems excessive since most members of the class of '67 are forty or under. Is there a problem with who is selected for Harvard or with the education experience or with career expectations? Does Harvard pay enough attention to teaching students and alumni how to cope with stress?"

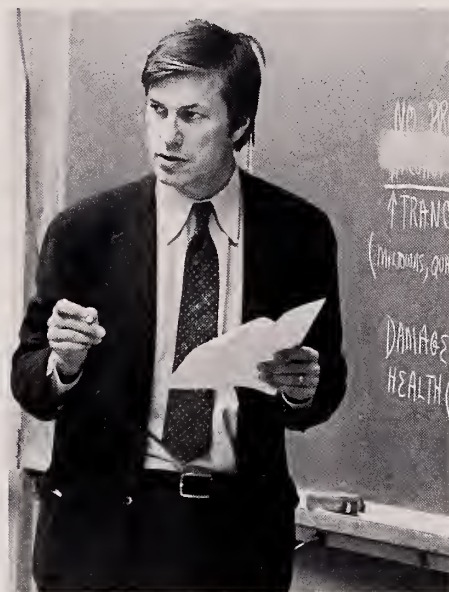
I have also seen unreason in the results of a long-range study which has followed a group of 268 men from college—before it was clear which of them might become physicians—to their sixth decade. The men were chosen in their sophomore year, out of classes from 1939 to 1944, for their academic, physical, and mental health. Forty-six of them became doctors. By the time they were fifty, drug use (regular use of tranquilizers or intermittent use of sleeping pills, amphetamines, and minor tranquilizers) was twice as great for the doctors as for the controls. Drug abuse (dependence on alcohol or drugs which damages a life, both occupationally and socially) was even more prevalent among the doctors: nine percent of the physicians versus one percent of the controls.

One of these physicians allowed diagnostic burholes to be drilled into his skull after developing nystagmus, ataxia, slurred speech, and seizures. Certainly one possible diagnosis would have been brain tumor. A few months after the holes were drilled his doctor was smart enough to test his blood for barbiturates, and only then discovered that his doctor-patient had been abusing sedatives for several years. The doctor-patient had denied it; his wife had denied it; the medical profession had denied it—yet it is sort of irrational to let people drill holes in your head.

The physicians in the long-range study also had a somewhat higher rate of unstable marriages. One marriage deteriorated to the point that the physician moved to the basement of his home. He prided himself on restraining his anger, asserting that the only thing that annoyed him about his wife was that she sometimes talked too long on the phone. He contemplated suicide, but fortunately had a good doctor who suggested that he see a psychiatrist. The doctor-patient explained that he was too busy to do anything like that. His physician asked, "Look, if a patient of yours came to you with this kind of a story, what would you tell the patient to do?" The potentially suicidal doctor got the message.

One of the advantages of following college sophomores into their sixth decade is that you can see things develop over time. One of our evaluation techniques was to use a blind rater—on the basis of ratings at eighteen—to select the sixteen "best" childhoods of those who became physicians and the thirteen bleakest. We found that drug use among physicians with the best childhoods was very similar to drug use among the controls. But the doctors with the worst childhoods later practiced an enormous

amount of self-medication. This does not mean that medical school admissions committees should not admit people with unhappy childhoods. Some of the very finest physicians—the ones whom you would want as your own—are doctors who have had painful childhoods. Empathy is often learned



the hard way. My point is that such individuals need to receive as well as give care.

I was asked recently by a lawyer to explain the term "impaired physician." My answer was that an impaired physician is really a code word which refers to the countertransference problems that hospital administrators and department chairmen and presidents of hospital boards have toward physicians who are in pain, and who misuse drugs, and who suffer psychiatric illness. Those with the countertransference problem initially tend to deny that anything is wrong, and then to feel anger at the impaired physi-

cian; they may even convince themselves that the physician has done something wrong.

At a great teaching hospital, for example, a resident made a suicide attempt during a period of crisis. A week later the resident was fired. In the same hospital, house officers who were seen crying in the pediatric intensive care unit were sent to the psychiatrist, as if there were something wrong with them. Another teaching hospital has physicians on the staff who in the past have abused opiates. Although the usual protocol would be compulsory urine monitoring, there is still no provision in that hospital for such testing. Yet the idea of a hospital not being able to test, for instance, the urine of diabetic physicians is inconceivable.

These stories seem inhumane, and yet they come from reasonable hospitals and reasonable people. They are the result of doctors failing to care for both doctors and themselves as they would other patients. I can only explain it by the psychoanalytic term, countertransference.

Let's turn now to the coping strategies of physicians—unconscious adaptive styles that in psychoanalytic argot are sometimes called ego mechanisms of defense. There are four such mechanisms that doctors tend to use more than other people. Under stress, they can be used maladaptively; when well used, they enhance effective functioning—like clotting mechanisms in the body, or callus formation.

The first defense is altruism: doing unto others as you would want others to do unto you, with the important proviso that you get paid for it: for example, the surgeon who nobly gets up at three in the morning for a patient gets to drive home in a Ferrari. Giving unto others only becomes a strain when you're giving more than you yourself receive. One physician, from another study of physician-addicts, never really achieved altruism. Instead he used to comfort himself by inducing ravenous hunger through self-injected insulin and then consuming a gallon of ice cream. He later substituted narcotics as a more efficient form of solace. Treated for his narcotic addiction, he developed a habit of drinking a gallon of milk a day.

Altruism is a neat defense; it didn't do Schweitzer any harm at all. But it's important to realize that it can put people at homeostatic risk. You've got to have as much coming into a system as you give out or you're in trouble.

The second defense that doctors use more than others is reaction formation. That is doing the very opposite, with passion, of what you would really like

	1970		1980
	90 CONTROLS	46 DOCTORS	46 Doctors
NO PROBLEMS	81%	67%	48%
ALCOHOL ABUSE	8%	4%	9%
↑TRANQUILIZER (INC. MILTDONS, QUALUDES, DEX AMYL)	10%	20%	28%
DAMAGE TO HEALTH (SOC OR MED)	1%	9%	15%

Incidence of alcohol and drug abuse among controls and doctors in 1970; and incidence of such abuse among the same doctors in 1980. From the Grant Study.



Altruism can put people at homeostatic risk. You've got to have as much coming into a system as you give out or you're in trouble.

to do. For example, consider the cigarette addict who throws away his cigarettes and then points at ashtrays and says, "Yuck, a disgusting habit," when he is just dying to have one. Reaction formation in doctors is most dramatic in the area of dependency. According to the results of the Terman Study—a random sample of 800 individuals in California with IQ's over 140—people who go into medicine are more dependent than those who go into other professions.

It's one of the interesting things about medicine: we like taking care of other people because we are dependent, yet we tend to keep our dependency needs secret from ourselves. One way of doing so is to say when we get sick, "Gee, I couldn't possibly bother Dr. Jones. If I went to see him, it would disturb him. I know how hard he works, and besides, if I saw him there would be no fee," rather than thinking, "Neat: if I get sick, I can go to Dr. Jones, and it won't even cost me anything."

Reaction formation can go to extremes. One doctor drove seventy miles

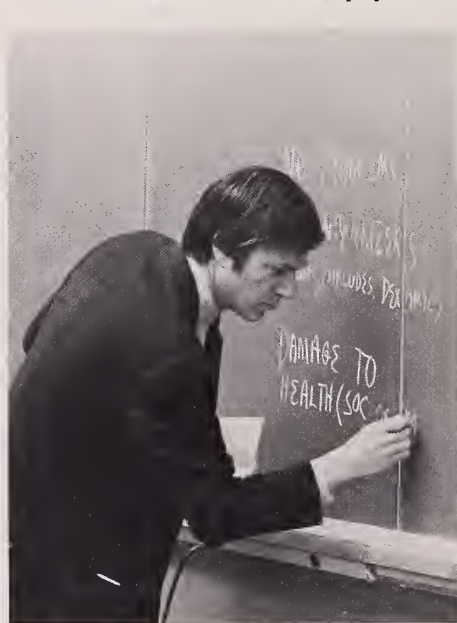
from Vermont to see me. He described a habit of injecting narcotics into his thigh with unsterile technique while driving to work at high speeds on the superhighway. Yet even then he wanted to deny the problem. In the course of the consultation he told me, with tears streaming down his face, that he wasn't depressed and didn't need help.

I'll give you an example of reaction formation that's closer to home. When I was in medical school we had to go to the health services for a physical exam. Down the hall was a sign that said 'Dr. Bojar', and people were sitting outside his office. I knew that he was the school psychiatrist. I thought, those poor bastards—having to be humiliated and subjected to this terrible thing of going to see Doctor Bojar: the name still conjures up a certain amount of horror.

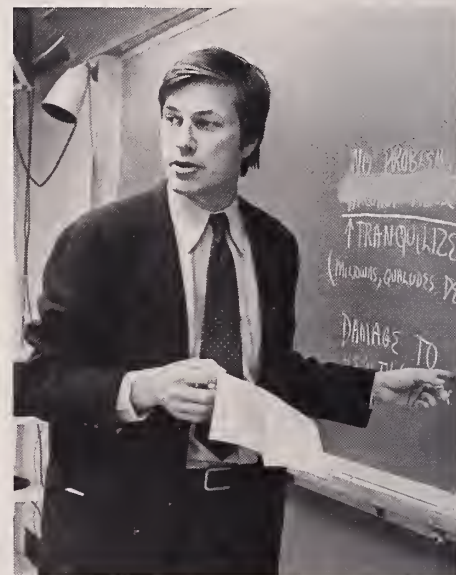
A few years later, I was the psychiatrist to the Tufts medical students. I thought it was a neat job: I was a splendid fellow, and the students were lucky to see me because it didn't cost them anything. The sensible students came to see me when they had troubles, and the ones who didn't were dumb. And I never made the connection, as to what in God's name was going on—that I would be perfectly willing to accept other people's dependency, while the thought of ever using one of those people myself was a fate worse than death.

The third defense mechanism physicians use is to turn the other cheek. Remember, turning the other cheek is tricky; the fact that it's called passive aggression is no accident. But it's a reinforcing way to express aggression, because society loves a martyr: people want their kindly G.P. to come through the snow to see them at three in the morning.

The mother of one of the physicians



in the longitudinal study said that when her children were two, she "used to give them switches and have them switch themselves when they were naughty." This is a rather extreme way of illustrating how some physicians are socialized way before they get to medical school. Being a martyr isn't something that you necessarily learn here; it isn't something that is done to you by these marble buildings. Of course it's important in medicine not to show anger towards your patients. But it's an oc-



cupational hazard that one absorbs a great deal of anger and doesn't have any terribly good place to put it. Doctors need to develop healthy outlets for anger.

The fourth defense, to which I've already alluded in several ways, is dissociation, or neurotic denial. Dissociation is the feeling I had all through my internship, that only a silver bacillus could catch me—I've never believed in the germ theory with regard to myself.

Dissociation, like the other defenses, can go to extraordinary extremes. One of my colleagues, to help me illustrate the denial used by doctors, gave his case history of cancer to a Tufts class. He told an incredible saga of ignoring a growing exhaustion, until his wife found him asleep on the floor one morning and insisted that he see a doctor. His hematocrit showed that he had bled out half of his blood volume: he had intestinal cancer, and was operated on. He presented himself to the class as a five-year cure. He said, "It's neat, you know, having had cancer the way I have, because I've had one cancer and that means I won't get another and I can go on smoking."

That attitude just doesn't make sense. When marathon runners get tired,

they look upon sleep and fatigue as friends. They don't try to stamp them out. What do you do when you have a patient in the hospital with pneumonia or an F.U.O.? You don't pour aspirin down his throat. You get a chart, and you chart the fever, and you use the fever as some index of what is going on, as your friend. What do doctors do when they have trouble sleeping or get tired? They take pills like Quaalude and Dexamil to stamp out such symptoms, rather than seeing the symptoms as signs they may need help.

What are the rules for dealing with all of this? First, you should realize that although altruism is a super defense, you should make sure that when you give to others, you're also given to. It

doesn't mean that your childhood has to have been perfect—your past isn't inevitably going to follow you around all your life—but it is important that you make sure you're cared for now.

Next, find ways of expressing anger. They can be perfectly ingenious; I know you get a little practice in the second and fourth-year shows by evening the score with some of the people here who have made your lives miserable.

The last rule is really the most important, and if this is the only thing you take away with you from this class, it will be worth the effort. Never, as long as you live, take a pill that you have prescribed for yourself. Instead, ask a colleague to write the prescription. Under *no* circumstances should you ever

self-medicate your central nervous system, and the reason is terribly simple: all pills that help the brain feel better work, in part, because they are symbols of another person caring for you. If you do it for yourself, it's like trying to tickle yourself. It also puts you at the risk of getting caught up in all the unreason that goes with our profession.

My point today is not that medicine is impossibly dangerous, or that you're particularly vulnerable. It is simply that in order to deal with normal slings and arrows, doctors tend to use certain defense mechanisms more than others, and understanding them can help you pay attention to getting care for yourselves in order to care for others. Physician, cherish thyself. □

Apprehending Stress: A Dialogue with Students

Vaillant: Why would it be that doctors might have bad marriages and abuse drugs? What reasons come to mind?

Response: *Maybe their lives don't meet their expectations.*

Vaillant: Why would a profession as neat as ours—and it *is* a neat profession—not meet our expectations?

Response: *The immovable object of the institution, the frustration of dealing with patients' pain, trying to be empathic but still remain intact---*

Vaillant: Certainly the immovable object is a factor. I can remember at the end of my first year looking up at Building A as I went off for summer vacation and wanting to blow the whole damn place up. (laughter, applause)

But to be empathic and intact: maybe that is harder to deal with. Other ideas?

Response: *Lack of support from other people in the same profession?*

Vaillant: Do you have any idea why that would be?

Response: *I just see that in medicine, even though you have friends and colleagues, you can't reach out to those people when you're really in trouble.*

Vaillant: Why? It doesn't make any sense: we're all so nice and we're all so eager to reach out to other people.

Response: *Insulation from feeling that way yourself.*

Response: *Competition.*

Vaillant: What is it about competition

that would not let us turn to people for help?

Response: *Others might discover something before you.*

Vaillant: But isn't that what we hire doctors for? The reason you go to all that trouble is so that the doctor will discover something before you do.

Response: *You don't want to feel that you know less than your peers.*

Vaillant: That we would end up being human instead of demigods? (laughter)

Response: *Some of it might be that the patient does regard you as a demigod, and you know inside that you're not, you're very human, and there's always that tension. You can't get away from it.*

Response: *Learning medicine involves a high degree of conformity. There are standards; everybody does well all the time. You're allowed only a very narrow role. You can't not conform; you can't be weak, or go to someone else for help---*

Vaillant: It's crazy, isn't it? You learn in medical school about human weaknesses, yet doctors won't apply what they know to themselves. What you're saying isn't common sense; it's like the most primitive sort of superstition.

Response: *It's too frightening. We've learned so much about diseases, and if we had to walk around thinking that all those things could be happening at any given moment we'd go crazy. It's a kind of blocking out mechanism—to maintain a little sanity.*

Vaillant: I can give you a first-hand example of how that works. When I was preparing this lecture, I was quite happy to discover the letters from the class of '67. Then, two nights ago, a classmate of mine reminded me that our class, '59, had six suicides in it, a fact which had never even crossed my mind in the preparation of this lecture.

What are your thoughts about why doctor's marriages might be bad?

Response: *Not enough time to spend at home.*

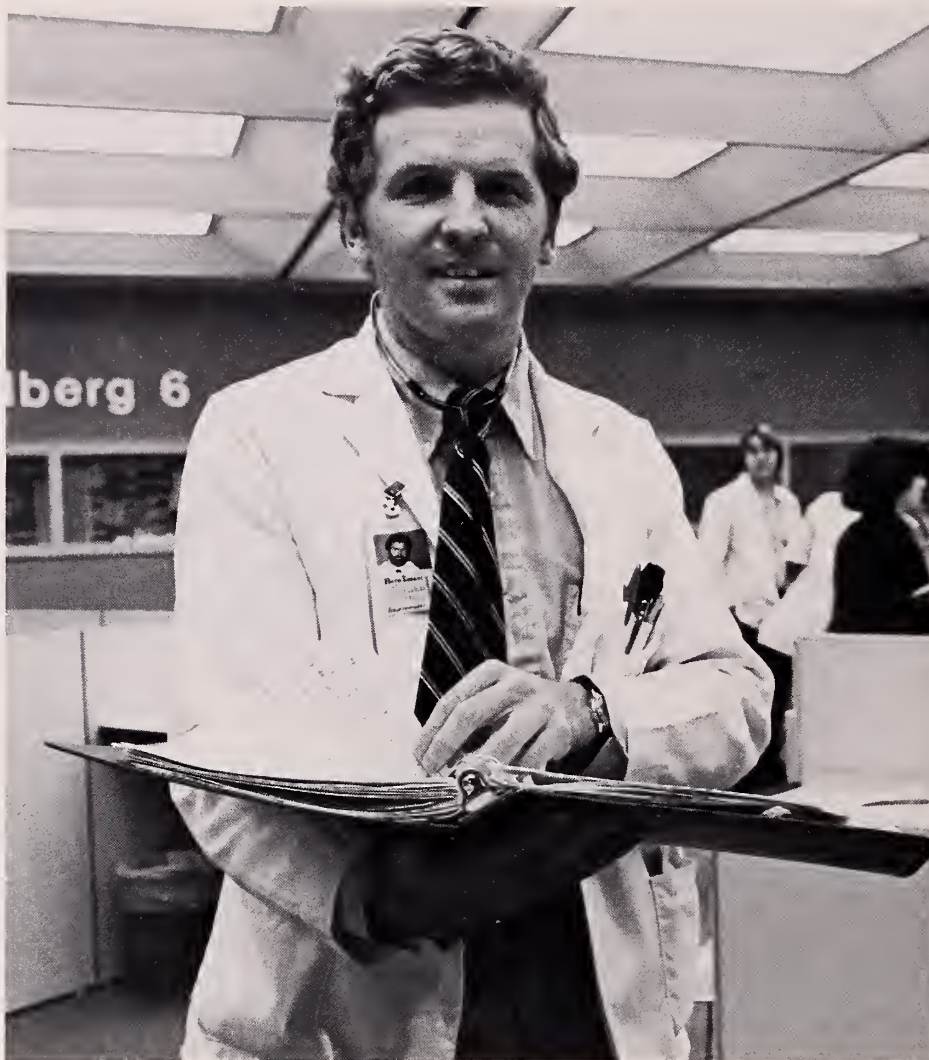
Response: *Polarization of importance—when one person has a job where he can come home and say, "I saved a few lives today. What did you do?" (laughter) It makes it tough.*

Vaillant: Sounds like justifiable homicide to me. (laughter) What else?

Response: *The selection by medical school admissions committees might rule out a lot of people who would pay more attention to other people instead of to their own goals.*

Vaillant: So that basically what medical school does is to pick nasty, dreadful people? (laughter)

Response: *It may not be that medical schools pick horrible people, but I have a feeling that the medical education process reduces us at certain points, like internship, to the bare essentials. You have to be egocentric just to survive, and once you do that, you can come out fundamentally changed—and maybe not in a good way.* □



Life (So to Speak) After Medical School

The Method and Madness of Internship

by Ward Casscells

In a sense, not much is known about internship. Those of us who have gone through it have our memories, to be sure, though memories—especially the very painful ones—tend to fade. There was not a lot of time for digesting; many say the year was just a blur. And there was even less time for communication—which makes it hard to know exactly how our fellow interns weathered the experience. It is also hard to know what it *really* would have been like at a different hospital, say, or in surgery instead of medicine. Most of all, though, it is hard to judge how well that year prepared us for the rest of our careers.

I interned in medicine two years ago at Beth Israel Hospital. The standards there were extraordinarily high—not only in science, but also in the warmth and responsibility of the nurses and private physicians. All this was hard to live up to. I was an average intern, I think, though inefficient; and survival meant having to change in certain ways. There were some wonderful teachers, including Lew Landsberg, George Kurland, Ted Steinman, Steve and Pat Come, Bob Brown, Bill Taylor, Mark Aronson, Bill Docken, Roger Lange, Scott Johnson, Frank Epstein, Fred Kantrowitz, and Bob Master.

I have a lot of memories, mostly bittersweet. One is of a very demented 86-year-old lady in septic shock, whose illness kept me up all night while she spat at, clawed, and cursed me. “Go away,” she yelled. “You’re killink me! Such torture!” I cursed her back, under my breath. A daughter later asked her why she had been so mean to the nice intern. Struck dumb that she understood this question (and so few others), imagine how I felt when she answered, “So he should get the *mitzvah* (blessing).”

Beyond the anecdotes, there has been very little research on house staff training, in contrast to the burgeoning literature on depression, alcoholism, and suicide among doctors in general.¹⁻⁴ While this may stem from sheer lack of interest on the part of researchers, grantors, or editors, it has been called “a conspiracy of silence.”⁵

Despite the paucity of studies on internship, at the September, 1978 Conference on the Impaired Physician, the AMA cited house officers as a group at

Ward Casscells '78 is currently a third-year resident in internal medicine at the Beth Israel Hospital and will be at the Massachusetts General next year as a cardiac fellow. His research interests encompass cardiology, epidemiology, and medical ethics, and he is the author of several dozen papers in those fields.

special risk. And in Britain last year the House of Commons proposed radical changes in medical training programs because, with 90-hour weeks for interns, "standards of care are adversely affected."⁶

The few attempts to explore this problem offer some intriguing psychological and sociological observations. A landmark descriptive study⁷ of two 1960 internship programs found them to be a kind of initiation designed to break ties with family and friends and to inculcate new values and identities, including group loyalty, and a sense of entitlement to high fees after the period of deprivation. One group has hypothesized that "the sleep-deprived intern acts out an unconscious wish widely held by physicians to possess abilities and powers that transcend what is ordinarily thought of as human."⁸

Others rationalize sleep deprivation among interns as an educational function: "A disease does not submit to an 8 to 5 routine. . . ." To follow the disease "...there is no substitute for long hours. . . ."⁹

Activist residents—appalled that they are considered students by the NLRB but workers by the IRS, so that they pay taxes but can't strike—cite Institute of Medicine estimates that 84 percent of their time is spent in service to patients, and thereby to private or staff doctors, who are relieved of much of the burden of the patient care for which they charge.¹⁰

Such explanations of why internship is as it is, in a sense, premature since there exists no consensus as to what it "is," or should be. There are few quantitative studies. A sociologist described the workload of Australian interns as "savage," noting, "The interns and their families invariably complained of the damaging fact of the long hours. . . . Both partners found it intolerable. . . . There was a lot of bitterness."¹¹ Neither the "workload" nor the "long hours" were quantified, however.

In another report, many family practice residents were found to have too little time to spend with their spouses, trouble communicating, and decreased libido. The authors found this "unnecessary and deleterious."¹²

Although interns might be expected to adjust after a few months, a systematic study of pediatric interns at USC found that over the year they became more dissatisfied with the workload, the teaching, and the emotional support. They developed a lower estimate of the role of social factors in health, and of the importance of the doctor-patient relationship. Sixty-four percent of their marriages suffered

At Columbia, sleep deprivation in medical interns led to depression, paranoia, regression, depersonalization, memory dysfunction, and impaired recognition of cardiac arrhythmias.

severe or moderate stress. "They start out enthusiastic and become, in many instances, disillusioned and bitter." Said one intern, "Internship is America's last sweatshop," and another, "You forget who you were and die a little."^{5, 13}

A 1975 study of Barnes Hospital residents from varied specialties found a 30 percent incidence of depression, 25 percent of these having suicidal ideation. There was also a 69 percent rate of impairment in patient care (a subjective assessment by the authors).¹⁴

At Columbia, sleep deprivation in medical interns led to impaired recognition of cardiac arrhythmias, as well as depression, irritability, paranoia, regression, depersonalization and memory dysfunction. A sampling of comments from subjects in the study: "When I'm tired, even though my mind is active, I can't think"; "My home life suffers and I miss my wife"; "I feel ashamed that I get tired"; "I give bad care to my patients"; "I think it has changed me permanently, and not for the best. It has made me more selfish, more inconsiderate in the free time I have, more dependent, and more depressed. No one would believe the effect on my life in general."⁸

It should be noted that the Barnes study reported 100 percent participation among residents in that hospital, while the Columbia study does not give these data—raising the possibility of selection bias in favor of unhappier, more vocal interns.

The problem of selection bias looms even larger in anecdotes, of which the following is a widely reported example: Last July, a 25-year-old married male surgical intern at Strong Memorial Hospital, an honors graduate, popular,

well respected, "the most level-headed" student in the class, was making the inevitable mistakes of the first month of internship. He was working 120 hours a week. He "blamed himself" and "felt inadequate." "He just kept saying people were dying left and right and he couldn't get any help." Given a leave of absence, he visited his parents and hanged himself in their basement.¹⁵

Also anecdotal is *The House of God*¹⁶, a barely novelized account by a former Beth Israel medical intern, written in the heat of an anger so blinding that, for all its truths, some BI physicians were, I think, unfairly maligned. Despite being pilloried in the *New England Journal of Medicine*, the book has been championed by interns around the country. Its pages are peppered with "buff and turf," "sieves and walls," "gomers go to ground," "placement comes first"—the now-familiar language of the internship underground, strange and inhuman as it must sound to the uninitiated.

In his remarkably wise and witty 1979 Class Day address,¹⁷ Ned Cassem advised interns to "Run away sometimes, hate often [and] complain constantly." But he also cautioned, "Let no one hear you except those who understand." For the complaints about long hours sound like just so much selfishness in comparison to the needs of the suffering and the dying. After all, aren't those doctors the same competitive, amoral premeds, who have become, through medical school, even more cynical and less caring?^{18, 19} As Jack Geiger said in a recent address at HMS, "They arrive wanting to do good and leave wanting to do well."

Speculation of this kind was provoked when Norman Cousins spoke out in *JAMA* last year,²⁰ concluding that "The custom of overworking interns has long since outlived its usefulness. It is inconsistent with the public interest. It is really not worthy of the tradition of medicine."

The responses were memorable: "Never did I or my fellow interns, who walked silent and compassionate through dark wards filled with the smell and rustle of suffering, ever wish for the quick death of any patient to relieve us of our duties. Never were we more alert and more capable, even after long wakeful hours, than when we struggled with the enemy, Death."

Another wrote: "Am I to assume we won World War II because we had more sleep? Would Henry Ford and Thomas Edison have not been great without their beauty sleep? . . . The tenor of Cousins' whole discussion is that of some bleeding hearts from the Occupational Safe-

ty and Health Administration who underestimate human strength and the will to succeed. Small wonder that mediocrity rules America!"

A third wrote, "How else could one learn the joys of...three hours of uninterrupted sleep?"

I asked an HMS professor, an ex-"iron-man" in his fifties, if there wasn't a little "blaming the victim" in these responses. He answered, "No, we really didn't suffer as much as they do now, even when we were on call every other night. You see, there was so little to do for the very sick—so few tests, so few facts, so little therapy. There was more time spent at the bedside, more time for teaching, and there were fewer chances to make fatal mistakes."

Long hours, apparently, don't tell the whole story. One current BI intern, respected for his conscientiousness and his kindness, had this to say: "Even when I'm rested it's hard. Let's say I have two very sick patients. Which do I see first—the sicker one or the younger one? I dread a stat page in the shower, and I can't sit on the john without my beeper going off. I'm often caught between the Private and the Visit, or between the nurse and the family. Everyone wants me at once—the EW junior [emergency ward resident] insists I pick up my hit [new admission] in the pit [EW]. Admitting [office] is spastic that I haven't signed a death certificate. I'm due to present [a case] at grand rounds five minutes ago and find out a crucial blood [sample] was missed by the tech even though the patient has veins the size of a garden hose."

Having insult heaped upon injury is another common complaint. One intern related: "The patient says that I'm nice but that she already has her own doctor—a real doctor—even if the last new drug he learned is penicillin. The nurse on ortho—a long walk up—refuses to take a verbal order to schedule tests. I spend hours on the phone, mostly on hold. A family dumps their gomer in the pit so they can go to the Cape. Even with good cases, the teaching is only fair, since half the Visits can't treat anything larger than a cell, and the residents are too busy to really check over my history and exam."

"The social workers say I don't care about 'psychosocial ecology,' but half of the patients are gomatose or hateful, manipulative addicts, and the rest are so sick and sad that I can't bear to go in their rooms. I don't have the time to get to know them, and even if I did they'd either die or I'd go off service. Sometimes I think Rule #9 [from *The House of God*] is right: The only good admission is a dead admission."

A Survival Manual for Interns

Ned Cassem '66, Associate Professor of Psychiatry at Massachusetts General Hospital, was the faculty speaker at Class Day 1979. His farewell address to students, entitled "Liberty, Death, Internship and Other Choices," was a serio-comic discussion of the risks and benefits of medical training. The speech first appeared in the July/August 1979 issue of the Bulletin. Here, we have bypassed the litany of risks—certainly a part of medical school folklore—and have reprinted Cassem's canon for coping.

You can expect, stress notwithstanding, greater learning than in any year so far, a new sense of mastery and self-confidence, multiple clinical skills, many unforgettable people and experiences. But learn your limits and try to live as close to them as you can comfortably tolerate.

1. Read the signal lights on your own psychic instrument panel: halt, tilt, amnesia, aphasia, gastritis, verbal incontinence, migraine, and so forth.
2. When these warning lights go on, you are being hit (now you know how your patients feel) — then it's first things first. Get the work done; go on automatic; shut off feeling; just make it last to the nearest exit, i.e., time off.
3. When you are hit, holler, even though you may have to save it up. To insure this you need your peer group. Stick together. Loners get hit harder. Women take heed, you are at higher risk. You have full complaining rights

with the same full vocabulary.

The group should be a good in-house Paranoid Club; let no one hear you except those who understand. Remember you are not in a club to change anything, you are there to complain. Do it creatively. Imaginary retaliation is better than none. Finally, when you've been especially creative, for instance you've come up with a Turkey Scale for Private Attendings, keep it anonymous.

4. Guard your time. You will never have enough of it again. You must claim enough for yourself and use it well.

5. Always fight down your grandiosity. Learn to tolerate uncertainty and the fallibility of your clinical judgments, and remain more impressed by the mysteries and uniqueness of your patients than by your own expertise. You are not God.

Learn to be grateful when you've been able to help someone even a little. Don't forget that behind your noble and committed selves are hearts, and there is no finer part of you. So give yourself a break. Hang on your office wall that lofty description of the physician's task:

To cure sometimes

To relieve often,

To comfort always.

But on the opposite side write Cassem's Perverse Laws for physician sanity:

Run away sometimes,

Hate often,

Complain constantly.

And ham it up a bit so your fellow doctors get vicarious relief. □

"I've sunk low enough to feel that way, but not low enough to shake the guilt. I'm angry at everyone, including myself. And who can I tell it to? The administration would call it weakness or laziness. They don't know and don't want to know. We can't take each other's time and spill our guts out. It's not fair to depress other interns when they're already on their knees."

Can these individuals be representative? Another intern acknowledged many of the same problems, but he took a philosophic view. "It's only one year. I just roll with the punches. Why get mad?" Others, more efficient, get the work done sooner and suffer less. A rare intern will even criticize fellow interns' complaints, as though "identifying with the aggressors." For women and minori-

ties, the problems may be worse yet, with persistent prejudice and few role models. For interns in smaller or less academic programs, away from the Northeast, the situation may be somewhat better. But once again, there are no reliable, representative data.

My guess would be that most interns are not miserable, and that in most training programs the good outweighs the bad. The real question is whether the programs, and the care of the patients, are the very best they can be. A few studies and a wealth of anecdotes suggest that they are not, but the care of patients and the training of doctors are important enough to deserve closer scrutiny.

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The Stresses of Medical School: A Smile Helps

by Lawrence K. Altman

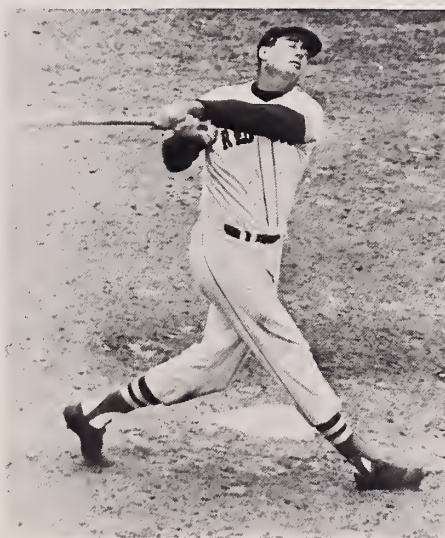
Ted Williams' baseball career with the Boston Red Sox was ending, and my medical school roommate, David J. Kudzma, was tempted. Should he go to Fenway Park to watch his hero in his last home game? Or, more dutifully, should he go to the library to read about a patient's disease?

David was serious, yet witty, and a talented future doctor. He was also an efficient student and a clear thinker, which explained why he graduated as a member of Phi Beta Kappa from Yale, where he was a classics major, and why he was at the top of his class at the Tufts University medical school.

In one of those uncharacteristic moments where emotions dominate over rational acts, David went to the ballpark instead of the library. In his bones he knew that Williams would hit a home run, and David wanted to be there. It was Sept. 28, 1960, and David sat in the rightfield bleachers, just 20 feet from where Williams' home run ball landed. It was one of the great thrills of David's life.

We were entering our third year of medical school, working in hospitals for the first time. For most of us, the change was welcome, but one that created a new set of stresses—those that went with the responsibilities of dealing with live patients, not cadavers. We had to learn how to interview a patient for a medical history, do a physical examination and standard laboratory tests, and to correlate the results to make a diagnosis and to outline a course of treatment.

The tasks required dedication and stamina. No matter what hour a patient was admitted to the hospital, we had to complete all these and other steps by the following morning, when we presented a detailed case to the professor on rounds. That meant we had to stay up many nights without sleep.



No one taught us how to adjust to that life style and to pace ourselves. We were supposed to learn to adjust by experience to our own needs. David's need was to go to the ballgame for a few hours of relaxation.

However, on his return, David was asked to explain his absence because he had not responded to his instructor's page. Dave could have come up with several explanations but he was honest.

His personality and that of the instructor contrasted starkly. The instructor was a physician who rarely smiled and who spent much of his time reading medical journals and reciting facts. He would score highly on medical examinations, but he was so wound up with the technical details of medicine that his patients seemingly had difficulty in relating to him in human terms.

As the instructor accused David of being unreliable and violating every sense of a physician's duty, the outraged instructor's face reddened from a flush of blood. Immediately, he

punished David. Each day for the remaining ten weeks of the course, David would have to test the stools collected from each patient on the hospital ward. David did the stool tests by the score in an incident that became a *cause celebre* in medical school.

About one in four medical students seek a psychiatric consultation for stresses which have been somewhat arbitrarily classified according to each of the four years of medical school. First-year medical students often become anxious and depressed because they are confronted by a mass of information that no one can learn in its entirety.

Many second-year students develop hypochondriacal fears and preoccupation with death from their initial encounters with the various diseases. In the third year, crises related to issues of intimacy and closeness can be provoked by contact with patients. And the increased responsibility of the last year, as well as anticipation of further responsibility as graduate physicians, can lead to even more mental stress.

Medical leaders and government officials have become deeply concerned about the high rates of suicide, drug addiction and other emotional problems to which physicians seem so prone. Each year the national toll from such disorders among physicians rivals the size of a graduating medical school class.

Equally important, many of those stresses and emotional problems reflect public criticism about the lack of caring and bedside manners on the part of many doctors. In the eyes of many patients, and even some physicians, too many doctors have become more technocrats than compassionate humans.

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Three from Sixty-Seven

Probing the Etiology of Stress in a Troubled Class

The class of '67 might best be described as a class caught in transition. They grew up in the fifties, went to medical school in the sixties, and began their careers in the seventies. Educated, for the most part, in traditional modes and edified by old-fashioned ideas about doctors and patients, they were perhaps unprepared for what medical school and medicine had in store for them.

This was the first HMS class to encounter a revised pathophysiology curriculum, and many apparently found it disorganized and confusing. They never knew their MCAT scores or their medical school grades—a phenomenon which had a paradoxical effect on some, at least. These high achievers suddenly had no means of calibrating their academic worth: anxiety filled in the space where grades had once been.

Simultaneously, unprecedented sums of money spilled out of federal coffers into biomedical research centers, and Harvard was a major beneficiary. The chief complaint among students was that the pressure to publish competed unfairly with quality teaching. And more than a few students felt compelled to spend summer vacation in the lab.

By the time the class of '67 graduated, medicine was swept into a maelstrom of heightened government intervention, third-party coverage, malpractice litigation, and technological innovation, while on the other side of

the world the US was embroiled in a war which made a mockery of everything that the healer believed in.

Whether any of these factors have been a source of undue stress for members of this class is only a matter of speculation. It has been pointed out, too, that the mortality and morbidity rates of this cohort are not remarkably different from those of other cohorts at HMS. But what does seem to distinguish the class of '67 is a willingness, even eagerness, to confront such unpleasant realities head-on. Three graduates of 1967, Thomas Gutheil, James Kahn, and Richard Reiling, do just this in the next few pages.

Reflections of a Survivor

by Thomas G. Gutheil

Seemingly ages ago, on one of those usually sedative-hypnotic medical school Wednesday afternoons, the mellifluous voice of Dr. Daniel Poskanzer, as I recall, was giving us a definition:

"A cohort," he said, "is a group of people growing old together."

It is far from strange that intimations of cohort membership should flock round the doorway of associations, as the reunion mail begins to pack the letter-box. There is, however, a

shadow over the notion, at least for me, and it is partly to confront this shadow that I write. As we approach our fifteenth reunion, seven of our classmates are dead, some apparently by their own hands. These members of our cohort did not get to experience the "growing old together" as promised. Yet by their demise they render the rest of us survivors.

Survivors are said to be subject to the phenomenon of survivor guilt: the feeling, What could I have done? As a survivor I find my thoughts turning to what might have been changed, what might have made a difference. At the last reunion the fiancée of one of my closer friends in the crowd commented that, by noting who returned more than once to the bar during the meal, one
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Bicentennial Etchings

by James B. Kahn

IMAGE: Amidst the pomp, merriment, and self-adulation that hallmark Harvard Medical School's jubilee extravaganza, members of the class of 1967 look strangely out of place. While high-spirited celebrants from other vintages jostle about boldly under the sun, this small cohort is huddled in a shadowed



recess of the Quadrangle. The object of their attention is a monumental stalagmite, its base encircled by mourning blossoms. It represents that class's grievous mortality. Colors are subdued, outlines indistinct. Their recollections tend to seek out three faces in particular, the three who have taken their own lives. The suicides represent a full two per cent of an HMS class that has yet to average forty years of age and they are sending out some sort of message that is still unclear.

The tragedy has not fallen with a single, merciful blow. Deaths and near-deaths have trickled down with menacing regularity for the past fifteen years. Hence the choice of the stalagmite as their testimonial. It is as if the survivors were trapped in some nitrous cave and

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Richard Reiling: Intensive Care

Richard Reiling is, as his classmate Thomas Gutheil would say, one of the "survivors" of the class of '67; but after spending hours in a cardiac intensive care unit, he doesn't take his survival status lightly. Reiling suffered a heart attack before his fortieth birthday. His recovery was accompanied by a period of prolonged introspection about himself; the stresses which may have contributed to his illness; his classmates, his school, and his career. Having articulated some of these concerns in correspondence with the Alumni Office, Reil-

ing was asked by the *Bulletin* to expand on them.

In a recent phone conversation we learned that Reiling, like his father and brother before him, came to HMS from Dayton, Ohio, to become a surgeon. He claims there was no family pressure to enter medicine, but that the desire was transferred by osmosis as he observed the almost palpable pleasure his father seemed to derive from work.

The product of a midwestern Republican background, Reiling says he wore a coat and tie to class every day at HMS. He was a member of an activist group of students who advocated a return to more structured ways of teaching medicine. He was also a supporter of the Boston City Hospital residents who staged a Heal-In to protest their

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Reflections

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could identify the alcoholics in the group. The point was obvious, but it struck me that it was not something I might have noticed before my clinical days. The woman who made the comment was herself not a clinician, but—given the ubiquity of addictions among members of our profession—her comment may have been the most significant remark at that reunion.

Was there something we might have learned in medical school that would have helped us reach out in some way to the lost ones of our class? Most of the lessons we received were rather of the other kind, pushing the wrong way, toward suppression and covering up. Certainly when we witnessed, as clerks, the sudden (and, at least one time, catastrophic) regressions to childhood to which our teachers succumbed in the operating rooms, we found few ways to make sense of what we were witnessing, and little permission to think about or discuss it with anyone. We had even less equipment for anticipating the effect on our own future development of capacities to handle the stresses that were to be part of the fabric of our medical lives.

There was little attention paid, as well, to the matter of our experience as students: only our psychiatry preceptors seemed to be aware that we were *having* any experiences of our own at all. And little attention was paid, it seemed, to what we might have offered each other by way of support. We had, of course, a special place in our hearts for the paratroopers—those intrepid souls who leaped down to ask that last question of the lecturer; and we sensed that we should, at least passively, “cover” for the “phantoms”—those classmates who honored student activities more by breach than observance. But was that enough?

Perhaps all this searching for what we could have done represents an exercise in futility, since addiction, depression and suicide are generally thought to spring from deep currents of character, biochemistry, genetics—sources beyond our feeble environmental reach. Should we be demanding that our admissions committees obtain family pedigrees to uncover the stigmata of affective illness or alcoholism, or does fundamental fairness preclude so mechanistic an approach?

I believe that there is one quarter from which these problems can be at

I was surprised when my internist asked me about vacations. A nanosecond's reflection revealed that this had more to do with my longevity and psychic well-being than most of what I had learned at HMS.

least approached. We need to understand a fundamental aspect of our chosen profession that is well described in the psychiatric literature regarding physicians but seems poorly disseminated among the non-psychiatric coterie. It is this: all God's children have to deal with dependency needs. Those like us who choose to be caretakers deal with those needs by letting others depend on *us* and then identifying with them as recipients of that care we would wish for ourselves. This complex but ubiquitous approach is highly adaptive, accounting for great success in the real world, but poses by its very nature a particular vulnerability, both to counter-dependency and dependency toxicity, or addiction.

As an example of the former, I recall an older orthopedics instructor on the senior staff who would sprint up the stairs with us, his clutch of students, and would succumb to dyspnea after two flights. He would maintain a stiff upper lip and try to conceal this quite natural result. It was clear that we could not have invited him to slow down, since his energies were bent on being our age in one way, at least. The counterdependent aspects of this vignette are self-evident.

Another situation, this time in a teaching hospital ER, involved a patient who had lacerated his feet while drunk and was intermittently quiescent and moaning, yelling or singing. As I stood in the corridor discussing some surgical point with the Chief Resident, we were interrupted by a fresh burst of yelling

from that patient, who lay in the nearby examining room. Without an instant's hesitation, the Chief strode into the room and whacked the patient violently on the head with the three-ring binder chart he was holding. The patient subsided, no doubt baffled by what had happened, though fortunately unhurt. The Chief returned to my side saying only, “I hate drunks,” and then resumed the didactic conversation.

Such behavior might be characterized as lacking in empathy, to say the least, but the point is that one might see this incident as the expression of hatred for an addict by a person bending over backwards away from his own dependency needs in violent repudiation (a reaction-formation, as we say in the trade). The resultant loss in personal flexibility and the ability to tolerate change and stress may well be imagined.

It is possible that by paying attention to such needs, and encouraging their honest acknowledgement, we might have loosened some of the pressure evident in the foregoing examples. Although we still might not have been able to reach in a healing way those classmates who needed it most, it might have done a great deal for the ambience of the class—no little feat!

Being deeply involved in forensic psychiatric activities, I enrolled in a course on “torts”, a basic first year law course, to learn how lawyers think. Being a clinician, I also studied the forces at work in the classroom that had nothing to do with the subject matter *per se* but had to do, instead, with what sociologists call “socialization”—the almost osmotic absorption by trainees of basic assumptions within a particular discipline.

These socializing forces were extremely significant and interesting—for example, law students seem to be encouraged to distrust altruism in any form and to look always for hidden self-interests. I found myself reflecting on the socialization we experienced as medical students, and what effects it may be having on us now.

Let me give an example. I was inordinately surprised when my internist, trained “elsewhere,” asked me, as part of the good old review of systems, about my vacations: how often did I take them and when was my last one? A nanosecond's reflection revealed that this matter had rather more to do with both my longevity and my psychic well-being than most of what I had learned at HMS.

Now this is not to say we should have had a course entitled “Vacations” wedged into our already hermetically packed curriculum; the issue, as I have

intimated, is one not of instruction in an attitude, but of an almost unconscious socialization. I am suggesting that this process that puts us out of touch with our dependency needs and their legitimate acknowledgement may have a great deal to do with both the strains of our profession and how we allow ourselves to cope with them. Perhaps our socialization could have been changed; perhaps for future classes it will. □

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Bicentennial Etchings

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are riveted in expectation of the next drop and the rocky accretion that will soon signal another loss.

□

IMAGE: Out from a spate of dreams looms the eight-hundred-year-old face of Maimonides. The sleeper has been disturbed by the death of a friend and his subconscious has conjured up poorly rehearsed lines that are fumbled on the stage, inanities mumbled before critical audiences prepared to hear profound wisdoms, and other jumbled visions of insufficiency. The medieval physician addresses the dreamer sternly. Only one man in a thousand dies of natural causes, he chants: the rest succumb to irrational modes of living. The dreamer awakens unconsolated and shivering.

□

IMAGE: Ina Jordan, serene homogenizer of American History, uses a subtle blue tint to highlight the hoary locks that are standard headwear for high school department heads in the late 1950's. She is the proverbial iron maiden with the velvet glove, able to bulldoze into submission even the most truculent of native adolescent intelligences. She needs no greater cunning, brandishes no heavier weapon, than her pithy rejoinder, "True, but..." Her basic gospel is a bedrock Yankee Republicanism, a bit too conservative for most of her pupils to be sure, but not *that* hard to swallow. It seems a small price to pay (moral spare change, nothing more) to be regarded as worthy by her standards. Integrity seems like a plentiful commodity that one can bargain away one small quantum at a time.

So Miss Jordan would ask her ques-

*We had been sure that we
could always reset the
moral compass later, once
we were in college and
secure. Or once we were
finally in medical school
and somewhat more secure.
Or later.*

tions and those eager for college would sense the desired answer and provide it. Those souls independent or brash enough to swerve in the least particular from the implied dogma received the mechanical smile and a "True, but..." Their fate was sealed. After three or four "True, but..." replies, a student might be doomed forever to the underworld of C's and D's. Surely only a sub-primate could miss her subliminal hints and persist in defending any other view of the world's affairs once Miss J. had issued a "True, but..."

Like a dulcet obligato, the phrase accompanied our slow and deliberate waltz from the early New England settlers through the Eisenhower years. Those who danced the tune in step were the "good learners" and advanced inexorably toward college. Only in retrospect and, then, only if we really cared to investigate, did we perceive the cost involved in this academic capitulation. We had been sure that we could always reset the moral compass later, once we were in college and secure. Or once we were finally in medical school and somewhat *more* secure. Or later. It never occurs to young people that a report card sporting straight A's could be a tarnished credential.

□

IMAGE: Several HMS scenes from the mid-1960's are spliced into a brief strip, a continuous loop that can be viewed starting at any point. The editor has not found it necessary to date these nor to

follow any real chronology:

—The dean's face mirrors his concern for the student before him. Ruler in hand, he gently but firmly administers the scolding. The student is to "shape up," or he may be "on the way out." The student has just lost his father and is hurt and confused. The dean, evidently, is unaware of this fact or assumes that it has no bearing on his charge's academic performance. The dean does not know the student's name and repeatedly calls him by that of another.

—Representatives of the student body have petitioned a Chief of Medicine for an audience: they now stand before him at one of the never-named Prestigious Boston Area Teaching Hospitals. The professor has heard their complaints many times before. Nobody is teaching them how to practice medicine, they say; the Chief Resident's lectures are invariably on exotic syndromes; their Visits only seem to want to know what the new admission's serum chemistries are, not how he or she is feeling. "We don't really care how you learn the basics," he responds. "Our job is to teach you that little extra that makes you distinguished." The students read between the lines: "distinguished" means "more like me." They depart only somewhat crestfallen, since they recognize this to be his sincere conviction.

—The junior assistant resident has had a very bad day. He calls an unscheduled "teaching conference" for the students on his ward. The words "classical" and "pathognomonic" scatter all about the room like a collapsing pile of logs. Students are intimidated, embarrassed before their colleagues. It is called a session on Clinical Pearls but it is really a game of "Can you guess what I am thinking?" No answer is accurate enough; all approval is withheld. It is a variation on the theme of "True, but..." It is considered a legitimate exercise in the establishment of the tyranny of the tenured over the neophytes. And, soon enough, the neophytes will learn how to play the master's role.

—The fourth year student has Boston internship in his soul and a twinkle in his eye. He awaits the perfect moment (timing is everything) on rounds before announcing at the bedside of the new admission, "I had occasion to review the world literature on rheumatoid arthritis recently." A rite of passage has transpired. A medical epistemologist is born; a glowing Visit licks his chops; his classmates bow their heads, acknowledging that a true Harvard Medical Man has just been separated from the Harvard Medical Boys. Monkey see, monkey do.

IMAGE: The little boy runs home to tell his father that he has just seen the best movie ever. "You haven't seen a good movie until you've seen Paul Muni in *The Good Earth*," is the devastating reply. The scene recurs painfully for several months until, at last, *The Good Earth* comes to town. The little boy tells no one he is off to see it and returns home to seek out his father. He finds him sleeping in his den. "Dad, dad," he yells, bursting with pride. "Dad, I've just seen the best movie ever."

"You haven't seen a good movie until you've seen Charlie Chaplin in *The Great Dictator*."

□

IMAGE: Pundits of the medical school admissions committee are contemplating a major change of direction for the institution. Incoming classes have been too heavily weighted with science majors; a readjustment of the tiller is in order. They decide to recruit more music majors, more graduates from the humanities. Their motto is "The Well Rounded Class."

"No. We need well rounded individuals," injects a dissident faculty member. The two factions square off and, after the predictably genteel donnybrook, decide to table all proposed measures and appoint a task force.

An intrepid minority continues to

argue that some changes can be made immediately. It makes no difference, they contend, whether a class is composed of a hundred well rounded individuals or a well rounded mixture of a hundred specialized individuals. The critical element is to pay more attention to the students already here.

"We need to spend time with each and every student, to cultivate his or her honest eccentricities. We need to help them identify their needs, identify the learning-impaired, realign those who've lost sight of their goals, help those more deeply confused see that they'd really rather farm a plot or write a score or sell cars. We must treat our students in the same humane manner we want them to learn to use with their own patients."

The meeting comes back to order. A majority finds that these recommendations are much too amorphous and, in any event, the changes suggested are much too drastic. The Harvard system has been in motion now for almost two-hundred years and the big anniversary is coming soon. This is not a time for dissension. Harvard must put its best foot forward no matter how tight the shoe.

And you can't shine a sneaker.

□

IMAGE: A worried physician talks to a senior vice president of the company

where his patient is about to lose his job. Management seems interested in what the doctor has to say.

The patient is type A, all the way, stressed and successful, a mid-thirties junior executive earning more money than he has ever dreamed of. Inwardly, unconsciously, he is convinced that his entire life's edifice is built on soda crackers and is going to crumble at any minute. His "productivity" is down, the vice president explains euphemistically.

"Naturally," explains the physician, "he needs to get some personal things in order before he can give his wholehearted effort to work again. His marriage and his children need some attention. *He* needs some attention."

The vice president claims understanding. But, he adds, "Those things can wait. He has deadlines at work. Those things don't have deadlines."

The physician goes a bit further. "Ah, but they do. Emotional deadlines are coming and going ignored all the time. Trouble is, when they pass unmet, we don't get fired or even reprimanded. We just chip a few more fragments off our drying topsoil. The heart gets a bit deafer and dumber. The patient dies a little bit more."

The vice president retains his blank stare. There can be no agreement. The uncomprehending executive moves off, and what happens next to him we are

Practicing Medicine in the Eighties:

Janet, age 34, has just been offered an assistant professorship at a top medical school. A recent New England Journal article serves a warning that she is in an age group with lowered fertility levels. While contemplating the myriad rewards of her prospective appointment, she hears her biological clock ticking away.

Roger, age 34, has been married to Janet since they were third-year medical students. His own career has progressed at a steady, if unremarkable pace. The thought of his wife ascending the academic ladder ahead of him elicits pangs of envy. And he thinks it's about time they started a family.

With increasing numbers of women entering professional life, a whole new set of stresses in medicine has been created. Several years ago, psychiatrists Carole C. Nadelson '61 and Malkah T. Notman, and Penny Lowenstein (then an intern in internal medicine) attempt-

ed to learn more about the practice patterns, lifestyles and stresses of men and women who graduated from Harvard Medical School between 1967 and 1977. The results of their study, published in the November 1979 issue of the *Journal of the American Medical Women's Association*, were obtained from questionnaires which addressed such topics as specialty and practice styles and sources of family conflict. Graduates were also asked whether resources had been available for career and lifestyle counseling, and what further resources would have been helpful along the way.

Nearly half of the respondents said they had changed career directions after medical school. More women appeared to be entering the same fields as men, instead of restricting themselves to more traditionally "feminine" specialties. Concerns about dual-career families were becoming more pronounced, and there was a growing trend among male graduates to make adjustments to their

wives' careers. Women continued to assume responsibility for childcare, although many recent graduates had few or no children.

For purposes of analysis respondents were divided into three groups: (1) *Graduates from 1967-71* were mostly in their mid-thirties, had completed training, and were beginning to have families. During that five-year period, the investigators noted, medical school classes still contained a small number of women. (2) *Graduates from 1972-76* were in training and formulating career plans at the time of the study. (3) *The class of 1977* were interns when polled and were considered separately, as they had a much lower response rate than the rest of the sample.

A high level of involvement in academic activities characterized the group which graduated between 1967-71. The specialty choices in both the 1967-71 and the 1972-76 cohorts reflected that women still were gravitating toward

not privileged to know. But the physician begins to ruminate about his own deadlines. He thinks a lot about his many years in the Harvard Medical complex.

He recalls the psychiatric interview, seemingly more designed to unseat his balance than fathom his motives, and the great sigh of relief when he heard from the other newly accepted students the famous joke that it is harder to get out of HMS than to get in. But then he recalls, too, that full expression of the joke as four years of benign indifference. A famous study comes to mind: the psychological profile of youngsters destined to study medicine and their remote parents, the lack of approval, the achievements that were never quite accomplished enough, the well greased slide into HMS. What had Harvard given him? Another set of behaviors and mannerisms, a new language, the tacit promise that if he mastered all of these they just might approve of him?

But didn't he always tell his patients that happiness was simply a matter of choosing one's own obligations and fulfilling *them* rather than blindly pursuing the objectives someone else assigns you? That study again: the high rate of physician suicide, alcoholism, other drug abuse. Know what you are, he thought, and like it and you'll feel like a doctor. Follow any other path and the

best you can do is act like one. And people who only act the part will someday face a moment of truth when they will reach for the bottle or the pills or, in extreme cases, the rope or the gun, against their own imperfections.

□

IMAGE: Two 1967 graduates have approached the mythical Chief Harvard Statistician. He has reviewed their investigation into the high mortality and morbidity experienced by their class in but fifteen years of professional life. He looks up from their data and, without a dram of inflection, decrees it to be invalid. A sober reworking of the figures and tables will be necessary if the statement is to accede to journal immortality.

Granted, all those young deaths do seem tragically premature but they fail to satisfy the rigid demands of chi-squares and other tests, so they are not significantly different from the mortality patterns of previous or subsequent classes. Granted, three suicides, almost *three* per cent of the class, seems like a lot, but really isn't significant either.

Their anger wants to boil over. They try to remind him of what the word significant means, to suggest that even one of those deaths is highly significant, is an epidemic, is a number too huge to countenance. On the eve of its bicenten-

nial, the Medical School should be rededicating itself before all else to its primary task of training men and women to be healers. And yet, hasn't Harvard shown that she lacks that mystical "inner ear" to hear what is wrong with her own children? Doesn't the Chief Statistician think that, in some small measure, these deaths, these three suicides in particular, represent a failure on her part?

The students explain that they have no great desire to savage their institution and its faculty. They readily acknowledge that the seeds which eventually grew into such despair for at least three of their fellows weren't planted at Harvard. But wasn't it likely, they ask, that they were watered there? Is it too much to ask that someone should have been vigilant enough, if not to tear the weed out at its root, at least to trim its foliage a bit? Isn't correcting this oversight a proper function for Harvard Medical School as it looks toward its third century?

"True," replies the obdurate sage. "True, but..." □

James B. Kahn is an internist with a solo practice in Deerfield, New Hampshire, and serves as the Infectious Disease Consultant to six hospitals. He also places high on his list of accomplishments his year-round participation in ice hockey.

New Stresses Require New Adjustments

such fields as pediatrics and psychiatry, but that there was a perceptible trend toward other specialties. Notably, four out of 41 women in the 1977 group were surgical interns.

The divorce rate was low overall, the researchers found, but added that "the increasing acceptance of living together rather than marrying early... may mean that marital status does not completely reflect the relatively stable relationships which do exist."

In the group which graduated between 1967-71, the women experienced more conflict revolving around dual-career issues; many described several moves and compromises related to their husbands' careers. In the group which graduated between 1972-76, the men reported more dual-career conflict than their counterparts in the older group. It also appeared that compromises were shared by both sexes in the 1972-76 cohort, the researchers found—"reflecting either more egalitarian relationships,

or the fact that many do not have children and therefore have fewer issues which evoke conflict."

The way childcare was handled surfaced as the main difference between the sexes. Fifty-four percent of the men in the older group indicated that their wives took care of the children. An additional third of the wives were primary caretakers, with some help from the husband and/or babysitters.

As for the resources they found lacking during their career preparation, women mentioned the dearth of role models, particularly those who had successfully combined career and family. Men also cited the lack of role models, as well as the lack of good advising—especially nonacademic physicians or primary care providers. Many respondents recommended implementing a seminar to discuss available styles of practice or setting up a practice.

* * * *

Does a dual-physician family have a double dose of stress? A new organization, "Dual Physician Families," has been established to help couples with the unique stresses and special needs of joint medical careers. Members are in all levels of practice, training, and medical school. The goals of the organization are threefold: (1) To gather data on practice patterns, shared residencies, membership in professional societies, malpractice and disability insurance, and training programs supportive of married couples; (2) To share information concerning maternity leaves, child rearing and family growth within the constraints of busy schedules, and services for working mothers and fathers; (3) To develop a support structure through a newsletter, and regional and national meetings. For more information write Drs. David and Esther Nash, Graduate Hospital, One Graduate Plaza, Philadelphia, PA 19146.

Intensive Care

continued from page 27

\$1000-a-year salaries. Following graduation, Reiling himself trained at the BCH, and then returned to Dayton to practice surgery. He recently became Chief of Staff at the Kettering Medical Center.

In our conversation with Reiling we were struck by the depth of his feeling about medical school and how profoundly those four years seem to have affected him. As a student, he was critical of the educational experience offered here—a stance which has not changed significantly in the intervening years. But Reiling admonished us not to misinterpret his remarks as a condemnation of HMS. For they are, unmistakably, the remarks of one who truly cares.

ON COMING TO HMS: I was scared. I found myself surrounded by classmates from ivy league schools, and I was from the University of Dayton. Most of us had left academic environments of rigid structure, and at HMS we were suddenly in an atmosphere of flexibility and “noncompetition.” But of course we were competitive; we all wanted to be a chief resident at the MGH. I would have repainted the White Building to be on the surgical house staff there. Although I had always excelled in school, it was frightening to be among a more elite group of people all striving for the same thing, and the anxiety was intensified because we didn’t know our grades or our standing in the class.

ON HIS MEDICAL SCHOOL EXPERIENCE: We found the revised curriculum unstructured and the lectures confusing. The attitude then was that you’d learn what you needed to later, in practice. We felt cheated. A group of us thought that we should have a voice, so we drafted a revision of the curriculum and even got a grant to publish it. We weren’t trying to shake the world, only trying to learn to be doctors. We were saying, “Listen to us. We feel there’s a deficiency.” I thought that medical school should be structured, and I still do.

In 1965, ’66, ’67 the primary function of the medical school was to make inroads in research. Students felt the pressure from this, which was about as subtle as a sledgehammer. If you didn’t spend the summer doing a \$500 research

Maybe it's too late to dissuade one another from pursuing this or that pathway bent on destruction, but it's not too late to be alert to the signals of stress among our students.

project, you were considered run-of-the-mill.

Our teachers talked disparagingly about LMDs. If you didn’t go into research, you weren’t any good—you just didn’t have class. We thought we had class; after all, we were at HMS! To end up *nothing but* an LMD? It confused us.

Some of my friends, as a result, felt compelled to go into careers they might not have otherwise chosen. Some have since expressed dissatisfaction about the paths they’ve taken. As for me, I had planned to go back home after training to practice surgery. I wasn’t given a whole lot of support by my advisor for these aspirations.

I wish I’d had an advisor who really sympathized, who really got to know me, who told me I didn’t need to have any papers published, that I didn’t need to go to the MGH. I wish I’d had someone say, “You can go to Dayton, Ohio and be an LMD and be happy.”

ON EXPECTATIONS AND DISAPPOINTMENTS: I was very altruistic as a student. I had old-fashioned notions about medicine, about the kinds of doctor-patient relationships that just don’t exist anymore. Around the time I graduated from HMS, malpractice suits began to be a problem. Now they’re a constant threat.

In 1963 my father paid \$23 a year for malpractice insurance. Seven years

later the rates had risen 2000 percent. My colleagues talk about it day-in and day-out. Combined with third-party coverage and government intervention, this whole development really prevents us from practicing medicine in a meaningful way. Now we just have to follow the book—make sure you’ve given all the tests, covered all the bases, just in case of a lawsuit.

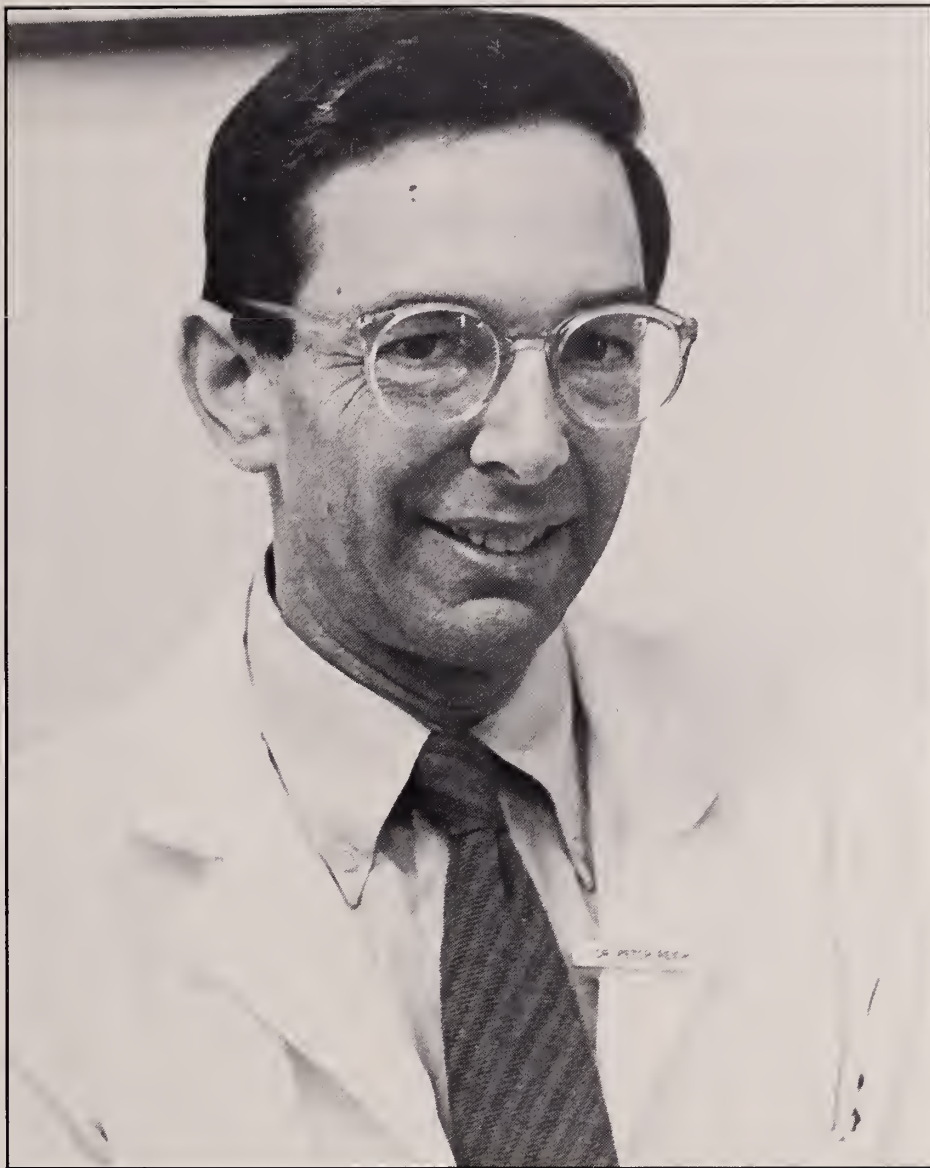
Some of my classmates have grown very cynical. I remember them speaking out in school, working for social justice, and now the same people who waved the red flags charge too much for treating hemorrhoids and look forward to early retirement. One never used to identify middle-age “job fatigue” with the medical profession. If I had to do it again, I’m not sure I’d go into medicine. I used to think what my father did was great; I wanted to do it too. My daughter, incidentally, wants to be a lawyer.

ON HIS HEART ATTACK: I have strong genetic factors, but I was also just about as uptight on the day of my heart attack as I ever was. I had a tremendous compulsion to be top-notch, to keep up with the literature, to drive myself. Of course, the patterns for these behaviors were established long before I came to HMS. But they were reinforced, I think, by the anxiety of an unstructured curriculum, the pressure to fit into a mold, the lack of direction from teachers and advisors.

ON THE CLASS OF ’67: I’ve thought a lot about the suicides among our classmates and wondered if we have failed, somewhere along the line, to prevent such psychological defeat. But I confess I have no answers, only more questions.

Now we’re in our forties. This is our peak; most of us are firmly established in our careers. Maybe it’s too late to dissuade one another from pursuing this or that pathway that is bent on destruction, but it’s not too late to be alert to the signals of stress among our students. I think the least we can do is try to help them to anticipate that changes will occur during their lifetimes in medicine and to help them learn to roll with the punches.

My allegiance to the class is as strong as ever. What made the greatest impression on me during medical school was the companionship and camaraderie among us. The relationships which developed there continue to be a source of strength and support, and I still maintain that the greatness of Harvard Medical School comes from its students. □



A Conversation with Peter Reich

Questioning the Source of Physician Stress

by Lisa W. Drew

Peter Reich '56, Associate Professor of Psychiatry, and Director of Psychiatry Services at the Brigham and Women's Hospital, is known formally for his work on the HMS Board of Advisors, and for his research—in psychosomatic medicine, on the biochemical basis of sleep, and on the effects of sudden emotional trauma on the heart. Informally, Reich has a reputation as a doctors' doctor. "A hell of a lot of physicians have beat a path to his door," we were told by Carl Walter '32 at an editorial board meeting.

When we approached Reich as a potential contributor to this issue of the *Bulletin*, he felt that he could not easily generalize about the stresses of medicine, and instead offered to share his reasons for that reluctance. The subsequent conversation unfolded in a way similar to that of some of the best scientific research efforts: the results were unexpected, but nonetheless compelling. The stresses of a medical career, Reich believes, are greatly overstated; in fact, he finds medicine to be among the best of all possible professions.

LD: The idea of doing an issue of the *Bulletin* on stress among physicians was stimulated by several rather poignant letters we received from members of the class of '67. They expressed concern about the death rate, and cause of death—notably suicides and heart attacks—among their classmates. As a psychiatrist with a number of physician patients, you were suggested by the *Bulletin's* editorial board as someone who could provide special insight into the subject.

PR: I do see a fair number of physicians; however, my impression is that it isn't the physician part of physicians' lives that leads them to have difficulties they might talk over with a psychiatrist. Their need for assistance comes, rather, from factors that are a part of their life history—that have come to them through their families, through their childhoods.

You raised the question of the class of '67. I have not seen the letters you mentioned or the figures on deaths in that class. But I would want to under-

Being a doctor can help you deal with the disturbing side of the normal life cycle. It may not protect you entirely from depression, but it certainly can be a positive force.

stand each person who committed suicide before assuming that being a physician played a role. And I certainly don't agree that heart ailments are necessarily evidence of maladaptive stress reactions. Did those people have strong family histories of cardiovascular disease? Did they have metabolic disorders?

I would say, let's look at the cases, look at the people. There were also a number of suicides in my class, '56. I was acquainted with those people, and I wouldn't want to suggest that it was because they were physicians that they committed suicide.

LD: Do you think there is anything unique to the medical profession that attracts a certain personality type?

PR: It's hard to generalize. Medical careers can vary all the way from running big corporate enterprises with multi-million dollar budgets to solo practice in, say, psychiatry, with a completely different lifestyle. There is a whole spectrum of choices, ranging from teaching in big-city hospitals to practicing in small towns, from research to full-time clinical work.

The variety in the lives of physicians also may reflect on the variety of motivations that bring people into medicine. The thought, "I want to be a doctor," could mean many different things. While I do think there are some traits that physicians have in common—perhaps "the wish to serve" or "the desire to help others"—I really hesitate to generalize.

LD: One of the articles I read in connection with this subject suggested that a certain type of individual is attracted to medical school—and that the problems encountered by that type come later. The term used was "obsessive compulsive"—someone who is achievement-and endurance-oriented, but not flexible, spontaneous, or creative.

PR: Again, I hesitate to say that medical students are different from, for example, law students, or physics students. Are you dealing with a special subset of problems? Or are you dealing with problems of high-powered professionals who go to school for years and years and who

therefore go deeply into debt, and who develop all kinds of expectations, and who are hard-driving, hard-working students because they never would have reached that level of educational achievement if they hadn't been?

I am also skeptical of the notion that doctors work harder than other professionals. Most independent careers involve an open-ended work pattern, which can include sixty or seventy hours of work a week, keeping up with the literature, attending meetings, being active in the community.

There are many factors to consider in seriously answering your question. Otherwise it's a kind of pop psychology. It's superficial.

LD: Your responses to my questions so far seem to have a common thread—that the consequences of the demands and pressures of medicine can be overplayed. Perhaps you'd like to comment on the other dimension of stress—the positive responses particular to the profession.

PR: You're raising the very point that I feel is underemphasized, namely the strengths, the healthy things in a medical career. What people seem to dwell on are the negative aspects of stress: sickness, suicide, breakdowns, alcoholism. I keep thinking about the notion that being a doctor can enhance one's mental health. Being a physician is a way to feel that you are doing something meaningful. Many people today are groping for meaning in their careers and in their lives, and it's not at all difficult to find it when you're helping out a human being.

There's also a lot of financial security in medicine, which I think shouldn't be minimized in this day of anxiety. A physician can count on being highly marketable, and can choose his or her

own place. Then there is the freedom to move, to choose a way of life, to thumb your nose at the organization and go off and hang your own shingle. There's protection from retirement. Retirement is one of the most stressful periods of life, and yet a physician can go right on working until he drops. Very few physicians observe a retirement age.

Being a doctor can also help you deal with the disturbing side of the normal life cycle: personal losses, deaths, illnesses, setbacks, the aging process, the midlife crisis. It may not do the trick; it may not protect you entirely from depression, even from suicide, but it certainly can be a positive force.

LD: It's been suggested that there is a socialization process in the education and training period that puts physicians out of touch with their dependency needs—that it might be a good idea to help students become aware of that process, to somehow say to them, "it's OK to have those needs."

PR: I don't have much sympathy with that point of view. I think there is a transition one has to go through to be a physician, and I think medical students do experience the stress of that transition. It can be frightening, and require confidence, to take control of another human being's life, to inflict discomfort, make major decisions, assume responsibilities. But it doesn't seem to me to involve the suppression of dependency—and I have not observed that my friends and colleagues have found it difficult to express their needs.

LD: You mentioned people who get satisfaction from the kinds of stress involved in practicing medicine...

PR: You call it stress. Stress is best defined in terms of the subjective experience of the individual, who, for all you know, finds it pleasurable to see his or her patients on a Sunday morning. I don't know if I would feel that way; but actually I do sometimes find being called for an emergency—even in the middle of the night—to be a satisfying experience. I'm needed, I go and do what I have to do, and I end up feeling quite good about it.

Stress is best defined in terms of the subjective experience of the individual, who, for all you know, may find it pleasurable to see patients on a Sunday morning.

LD: Is there anything about that that can backfire? Are there any risks in getting satisfaction that way?

PR: Not specifically. Putting your job and your satisfactions together so that you're really happy in what you do is a strong positive in the direction of integration. If you're fighting it, if you hate your work, if you're feeling put upon, then there might be a risk. If you are not happy as a doctor and yet you go on doing what you are forced to do by responsibility, stress can be set up. Conflicts within you can lead to a lot of unhappiness.

LD: Which comes back to the perception of stress...

PR: That's right. I also think there are different times of life for a physician, just as there are for anyone else, that might make being a physician more or less of a burden. As a student, as a house officer, as a young clinician, or as a faculty member, and so on up the line and down the other side—there are going to be particular characteristics of those periods which will be more or less stressful. There will be times when the demands of the profession conflict or agree with the demands of the normal life cycle. For example, if a physician has just been married and wants to be very closely involved with his or her spouse and then ends up with a great deal of around-the-clock duty, that's going to be perceived as stressful. At another time of life, that very same responsibility might actually be welcome, and might even be a satisfying experience.

LD: How do you account for the fact that several different studies have shown that physicians as a group tend to misuse or abuse drugs and alcohol more than other groups?

PR: I've heard similar statements and I always want to know more: How big is the difference? Abuse which drugs and how much? How is the word 'abuse' used? Physicians do have much more ready access to drugs and might very well self-medicate for pain, or for psychological highs, or whatever. Alcohol is more difficult for me to understand,

and I'd like to know more about it. I would be surprised if physicians were that different from comparable groups, such as lawyers, executives, brokers, and others with similar education and socioeconomic backgrounds.

Another interesting thing to look at would be marriage, divorce, and interpersonal problems.

LD: Apparently marital discord and family problems are quite prevalent. There have also been reports in the literature of a high incidence of alcohol and drug abuse among physicians' wives.

PR: That's the kind of statement that might represent a small difference and is now perceived as a big difference. I'd want to go back to the source of that information. I see, for example, a lot of young physicians who are having marital problems. You could say they work such long hours that they have very little to give when they get home, with nothing left over for their spouses.

But in looking at the couples that come to see me it's apparent that the seeds of the difficulty were there before medicine intervened. You wonder why these particular individuals are having difficulty, as compared to other, equally hardworking physicians whose marriages haven't broken up. You're still left with the question: what's special about the individual? It's not just being a physician. I think you have to be awfully careful before you jump to conclusions like "doctors have lousy marriages," or "doctors' wives or doctors' husbands suffer a great deal because their spouses are busy."

LD: I suppose that what we *can* say with certainty, in looking at the statistics, is that some people within, and close to, the medical profession apparently do

feel stress, do commit suicide, and do suffer heart attacks. The question is whether those reactions are related to the profession.

PR: I think you asked a searching question about the reasons that people decide to go into medicine. The Dean, at this year's orientation for first-year students, referred to the wish for power as a motivation for being a physician. As he pointed out, we tend to look at that as if there were something wrong with it, but it can be a constructive wish. You can define power in terms of having a right to do meaningful things in other people's lives. It may not be just an ambition in the potentially negative sense, but a desire for responsibility. Power and responsibility go hand in hand.

If one has unrealistic expectations, one is destined to be disappointed—the research person, for example, who is never satisfied with his work because of the underlying fantasy that he's going to do great, great things; therefore nothing he does is ever really enough. Does that mean that being in research predisposes you to depression? I don't think so. It's having insatiable ambitions that might subject you to depression.

People come to any job with complex motivations: They want to help; they also want to control. They want to heal; they also want power over life and death. Some people are going to become depressed whatever they do, because there are forces in them that have nothing to do with the reality of their experiences, but have to do with problems that they bring into every situation they enter. To assume that an individual had a breakdown or committed suicide due to unusual stresses in the medical world is unjustified unless there are hard data. I think this kind of speculative thought needs to be subjected to rigorous study.

Being a physician can be so satisfying that I wonder why people tend to assume it's so stressful. I find it to be one of the most exciting, varied, and challenging careers that a person can have. □

Beasts at Ephesus

It was a dog's life, with little sleep
and much anxiety — but he
wouldn't have traded it
for any other.

by Frederick C. Irving

In 1942 Frederick C. Irving '10 wrote Safe Deliverance, a book of reminiscences about his life as an obstetric surgeon. A chapter entitled "Beasts at Ephesus" easily serves as a treatise on the stress of medicine and its alleviation; and the forty years which have intervened since the piece was published have made it no less compelling.

At the beginning of the chapter, the patient, Mrs. MacDonald, has delivered a baby boy by caesarean section after being admitted to the hospital with moderate bleeding. An hour later she begins massive hemorrhaging. When a series of transfusions proves futile, the surgeon-author determines that "a hysterectomy now would be the only possible way of saving her life." The remainder of the chapter is reprinted here:

He knew that the shock of the operation might be all that was needed to kill her. In such a case indeed is "the occasion instant, decision difficult, experiment perilous." Although he realized that upon his skill and celerity depended the patient's life, nevertheless he felt relieved now that he had made his decision, for he had faced the same situation before and he was as eager to begin as is a soldier to attack when the order is given to engage the

enemy. He could not let her die without fighting for her life, even though he might be the means of her destruction.

For the past half-hour under his orders the operating nurse, swathed in gown, headgear, and mask, her instruments laid out on a covered table, and her gloved hands wrapped in a sterile towel, had sat waiting on a stool in a corner of the room. As he spoke she arose and called to the head nurse, who uncovered her table; and together they counted the gauze sponges that were to be used in the operation. The visiting man, the resident, and the senior house officer walked to the long sink at the end of the room, opened the elbow taps, and started a gush of water which added a steady undertone to the sounds created by the renewed activity.

The anesthetist, aided by a nurse, wheeled in a gas machine — a square gray table on casters, surmounted by a number of vertical gauge tubes each containing a different-colored liquid, and from which depended a cluster of long blue and green cylinders. There was a momentary hissing as the cylinders were opened and the apparatus adjusted. The mask, connected to the machine by two large corrugated tubes, was fitted to the patient's face, and the anesthesia was begun.

Presently the anesthetist said, "I can't get her blood pressure."

"Can you get her pulse?" asked the visiting man.

"Yes, sir. It is about a hundred and sixty but very weak."

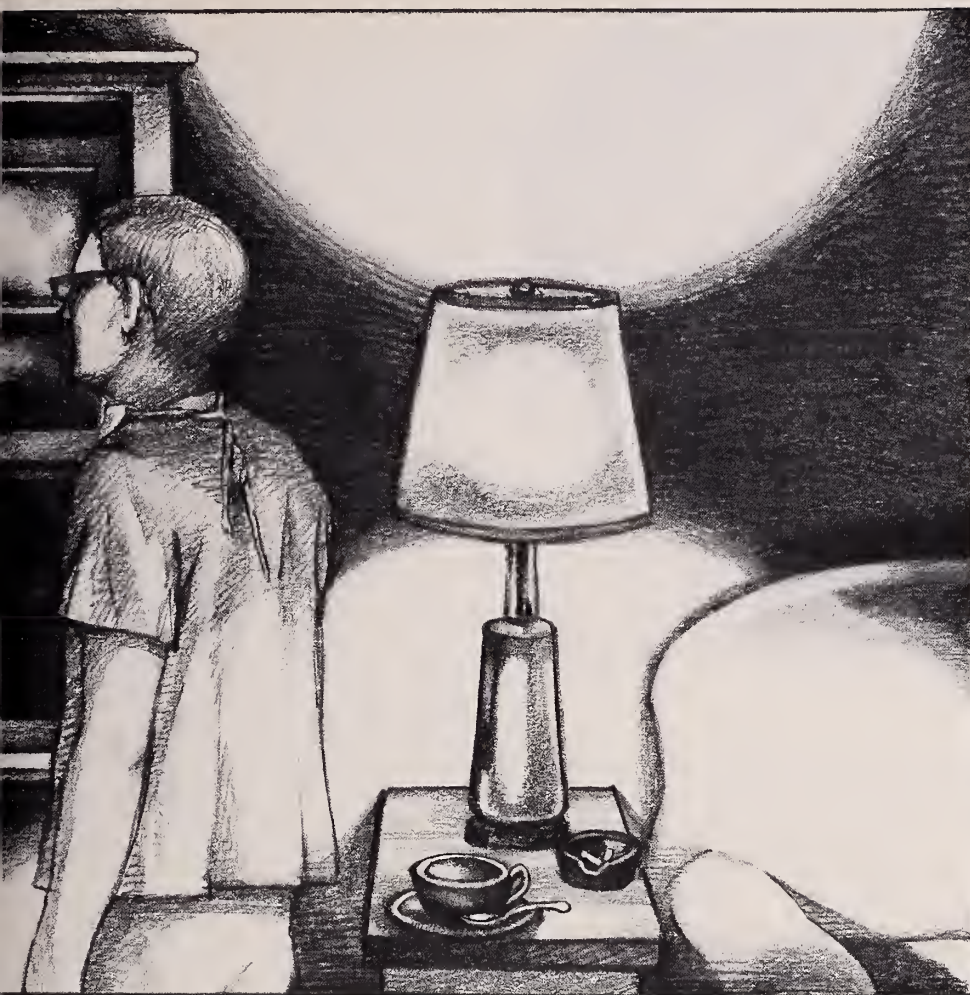
"All right, go ahead. Don't tell me anything about her condition unless she dies or unless I ask you."

"All right, sir."

In ten minutes the scrub was finished. The head nurse undid the binder, arranged the blanket, and removed the upper part of the dressing. The senior house officer lifted off the remainder with a sterile instrument and painted the wound and the skin of the abdomen with iodine. The resident and operating nurse rapidly draped the patient with sterile towels and sheets, leaving only the wound exposed. The visiting man stepped to the left of the patient with the operating nurse beside him and picked up a pair of forceps and scissors to cut the stitches, while the resident and senior house officer faced him across the table. The sleepy students in the seats aroused themselves and stood up so that they could see better.

In a few seconds he had opened the wound, passed a hand behind the pale, flabby uterus and lifted it onto the sur-





face of the abdomen. He clamped and cut its supporting ligaments on both sides, freed the bladder from it and secured the blood vessels supplying its lower portion; then with a knife he amputated it and dropped the heavy organ into a basin held out by the nurse, whose hands sagged momentarily as she received it. He then replaced the clamps with stitches passed about the arteries. So far the operation had proceeded silently and had not consumed more than ten minutes.

"How is she?" he asked the anesthetist.

"No worse."

He began the closure of the uterine stump, and at once he encountered difficulties. Every time the needle passed through the tissues there was an ooze of blood through the tiny perforations thus made, for sometimes in a badly exsanguinated person what little blood remains seems to have lost entirely its clotting power. Stitch after stitch failed to control this bleeding, which although slight in amount might well in time be enough to prove fatal if her abdomen were closed before it had been checked. The visiting man had begun to sweat, as some surgeons do during operations because of intense preoccupation or worry. A nurse stood beside him wip-

ing his brow and chin.

"How is she now?"

"Not so good, sir," replied the anesthetist. "She is breathing but I can't get her pulse now and then."

"Where's that next transfusion?" he asked the head nurse.

"The blood is almost drawn and Dr. Peterson will bring it right in."

"Well, tell him not to lose any time and to put it in under pressure."

Eventually, after what seemed to him a maddening delay, he succeeded in checking the oozing from the stump and ligaments by placing overlapping stitches, he wiped the abdomen clean and searched the operative field for bleeding points. There were none.

"Sponge count, please."

The head nurse had already hung each numbered sponge on its proper hook on the wall. The closure of the abdominal wall was proceeding and the transfusion was being pumped in.

"The sponge count is correct, sir."

The wound was soon stitched, and a small drain was placed to the stump to act as a tell-tale in the event of further bleeding. A nurse helped the visiting man out of his gown, revealing his operating shirt drenched with sweat. He took off his mask, wiped his forehead with it, and felt for the patient's pulse

at the temple and wrist as he looked at her face, noting the color of her lips and skin.

"Do you get it?" he asked the anesthetist.

"It's a hundred and sixty in her arm, and her systolic is sixty-four, but I can't get her diastolic."

The visiting man reached under the blanket and sheets to feel the patient's feet.

"Pretty cold," he said. "How many more donors have you lined up?" he asked the assistant resident.

"We've used up all the family that are compatible, as well as her friends, but we have two professionals."

"Good. Give her another one."

Presently the next transfusion was running in. This time it was effective, for the bleeding had at last been stanchied. Now that the leakage had been stopped, new hemoglobin was carrying oxygen to her depleted tissues, new protein was holding fluid within her blood stream, and her fluttering heart had at last been given something to work upon. Her pulse rate slowed, her respirations became deeper and regular, her face began to lose its pallor, and the lobes of her ears became pink. A successful transfusion in severe hemorrhage achieves the nearest thing to resurrection those of us who live today are ever likely to see.

Presently she moved her head, opened her eyes, and said, "Doctor, what time is it?"

"Six o'clock in the morning, Mrs. MacDonald." Then turning to the resident he said: "I think she will make it. Tell her husband that her condition is better."

An inaudible sigh of relief swept over the doctors, for they knew that that particular battle had ended in a victory.

The patient's pulse had slowed, her blood pressure had risen, her hands and feet were growing warmer, and the blood was returning to her lips. Leaving orders that the last donor was to be held and used at once if the blood pressure fell below its present level, the visiting man went into the surgeons' room. The stimulation that had sustained him all night had gone and he was tired, but after a cigarette and the coffee and toast which the head nurse had brought a grateful sense of relaxation pervaded him.

The house staff, singly and in groups, came in from time to time and discussed the case, asking what could have been done to prevent such an accident from happening again. For a few minutes there would be an animated discussion; then they would lapse into

silence as they re-enacted within their minds the events of the last few hours.

Before long they were interrupted by a knock on the door, and the night superintendent, immaculate in her cap and starched white uniform, looked in.

"There is an eclamptic coming in from East Boston, sent in by her family doctor in the police ambulance," she said. "He says that she has had five convulsions."

The resident looked at the visiting man and asked him if he should call the junior staff member on duty.

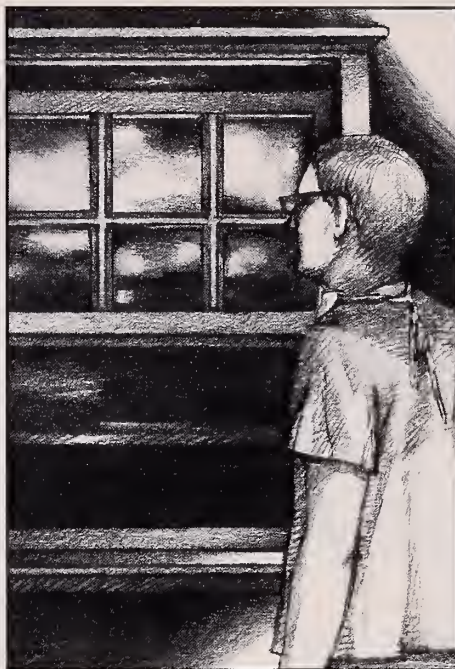
For a moment he did not reply. He had just been thinking that a warm bed and a long morning sleep, with no patients to see until the afternoon, would be the most desirable thing in the world.

"No," he replied. "I'll wait and look at her when she comes in and start treatment. You can ask him to carry on when he makes the visit this morning."

After the resident had left the room the visiting man stood up and lowered the window slightly to let in some fresh air. The snowfall had stopped, leaving the roof and cupola of the Latin School covered. In the distance the red aeroplane beacon on the Custom House Tower was still flashing intermittently; and behind a level bank of lavender clouds the sun was rising, already gilding the roofs of the downtown buildings, whose sides — a grayish-blue as seen against the light — showed yet no traces of windows.

What painter, he wondered, could have caught those colors? Whistler was always best on a foggy evening, but Turner could have done it superbly. Here the plasticity of oil was not needed; water-color alone could interpret the translucence and vibrant quality of this particular gold, lavender, and blue. Turner's picture most likely would be more vivid than this scene, but it would possess a lasting beauty; on the other hand, in a few minutes what he now saw would be gone. There was much in the world to delight the eye: the many shapes of clouds, the young leaves of willows in the early spring, the shadows of foliage on white walls, and stone fences and lilac bushes along the shaded country roads.

But he had learned to take these pleasures in secret, for more than once when he had pointed out to some friend a bit of form or color that had charmed him, he had met with the same polite apathy that would have greeted him had he shown sufficiently bad taste to recount an exploit of one of his own children. The world, he thought, was for the most part fair to the eye; and when the time came to leave it, its fairness would make departure



He had just been thinking that a warm bed and a long morning sleep, with no patients to see until the afternoon, would be the most desirable thing in the world.

more bitter. Mrs. MacDonald was lucky to be alive this morning; probably she would live much longer than he, for she was young and he was middle-aged.

Already a few automobiles had made new tracks in the snow on Louis Pasteur Avenue, and the city was awakening, yawning, stretching its arms, and rubbing its eyes. Why, he asked himself, had he selected obstetrics as a specialty instead of general surgery or internal medicine — or something easy like skin disease? Possibly because he had thought it would be exciting. Well, he had had plenty of that last night. It was a dog's life, with little sleep and much anxiety.

"Why," an earnest acquaintance — one of those unsmiling, unpleasantly candid individuals who transfix you with a penetrating eye — had once asked, "do you do obstetrics? Childbirth is a normal process. Nothing ever goes wrong. All you have to do is to sit around and wait for the baby to come. Why not leave that to the midwives? You are a man of fair intelligence, and you might have really amounted to something in some other branch of medicine." There had been times when he had almost agreed. How much more gratifying to one's self-esteem is the life

of the surgeon, who, surrounded by an acquiescent chorus of residents and house officers, adroitly abstracts an appendix, exhibiting at times the privileged petulance of a prima donna when a clumsy assistant gets in his way or the scrub nurse hands him the wrong instrument.

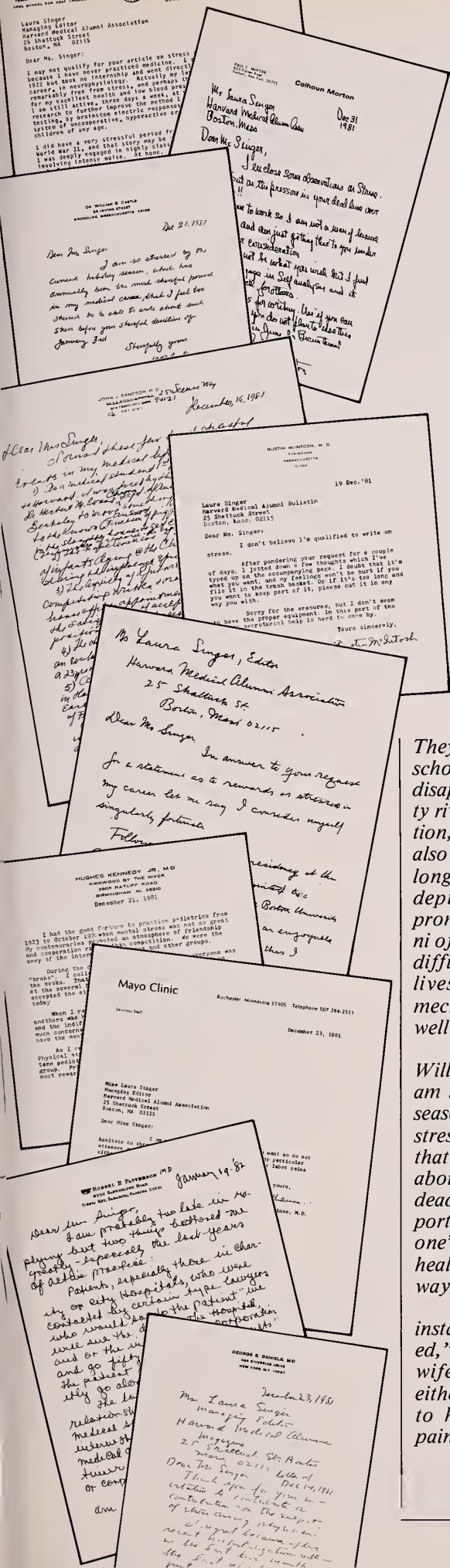
But for color and showmanship the modern surgeon falls far behind the legendary figures of the previous generation. Who today, for instance, can like Maurice Richardson make a tiny incision, whistle, and count upon the appendix appearing obediently in the wound? Who has taken the place of the diminutive Stubby Conant that peered with an elfin glance at the amphitheater audience around a huge ovarian cyst, like a short and rotund Atlas hiding behind his globe? Upon whom had fallen the mantle of Frank Watson, whose habit it was to stand with his back to his patient while he was popping out a prostate, and to end by flipping it over his shoulder and catching it neatly on his other hand? And where are the Shattucks, the Fitzes, and the Seares, who made accurate diagnoses by histories, physical examinations, and God-given common sense?

Today the medical wards are like the court of Nebuchadnezzar; for the magicians, and the astrologers, and the sorcerers, and the Chaldeans are summoned from the laboratories, the psychiatric service, the X-ray department, and the other secret and remote fastnesses of the hospital that they may perform their mysterious rites and work their incantations.

Possibly, he concluded, I am happier in my own simple surroundings. All last night I had nothing to do but to care for one patient; no rôle to fill, and no audience but a few tired medical students; in one sense it was peaceful. The hospital staff was superb, it functioned as smoothly as it always does — for emergencies may occur in obstetrics when they are least expected — there was no tumult; there were no false moves, no mistakes. Before I go, I must tell the resident and the head nurse how much I appreciate it.

I am glad that I decided to operate on Mrs. MacDonald, otherwise she would not be alive this morning; and now, when the time comes, she can go home to her children and her husband, which is no small thing. It would have been a bitter disappointment if I had lost her. "If after the manner of men I have fought with beasts at Ephesus, what advantageth it me if the dead arise not?"

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Remembrances of Stresses Past

*Our Most Experienced Alumni
Share Their Thoughts*

They've been through it all: medical school and training, appointments and disappointments, grand rounds and petty rivalries, epidemics, racial discrimination, the Depression. Most of them have also confronted the ultimate stress of a long and full career: retirement. This depth and breadth of experience prompted us to survey the oldest alumni of HMS for observations on the most difficult adaptations of their medical lives and recollections of coping mechanisms which have served them well.

A succinct reply from the inimitable William B. Castle '21 said only this: "I am so stressed by the current holiday season, which has always been the most stressful period of my medical career, that I feel too stressed to be able to write about such stress before your stressful deadline." Here we found buried an important message: Knowing when to limit one's commitments and maintaining a healthy sense of humor can go a long way in keeping the lid on stress.

"I have tried to remember specific instances of stress and have not succeeded," wrote Samuel F. Haines '19, "My wife can't remember labor pains, either." Others who responded seemed to have had no trouble recalling the pains of their labors.

Goethe said that every day one should listen to a little song, read a good poem, view a great painting, and, if possible, utter a few sensible words. The physician who, from his early years, has set his heart on the study of medicine and majored in the sciences has little time left for the arts. However, if one's natural bent is toward a wider cultural range, the suppression of one's artistic impulse can result in permanent regret.

In my own experience, an inextinguishable interest in a number of sidelines persisted to an extent that was incompatible with self-imposed professional standards. The outcome was that I retired from active practice at age sixty and took a salaried job with little opportunity to pursue research.

The concomitant desire to delve more deeply into my hobbies led, for example, to an interest in mycetism (mushroom poisoning), which I followed with satisfaction. In time my hobbies displaced my medical interests; and as I reached my ninth decade, much of my medical knowledge had become obsolete. Those who have retired from professional life and have not given adequate attention to their instinctive desires may feel a stress that has been absent from my experience. I have not regretted my own choice.

*Robert W. Buck '21
Waban, Massachusetts*

My father was a farmer with no money, and I went through Harvard College and Harvard Medical School on scholarships. To get to the medical school I rode a bicycle three miles from Lexington, took a train to Dudley Street and walked through Roxbury Crossing.

I had been diverted from a teaching career to medicine by Professor Thaxter, a specialist in cryptogamic botany at Harvard, who pointed out that life—animal and vegetable—died from a breakdown in immunity. He condemned physicians for treating illness while doing nothing to prevent it. I went into medicine to reform it.

Later, I switched from general surgery to Ear, Nose and Throat, finally settling in Providence, Rhode Island, where competition was lacking. I was unable to sell immunity to a wealthy clientele interested in living it up, not in living a long time. Very few submitted to going on acidophilus milk and injections of fungi and bacteria. The experiment had to be personal.

Financially I have had no problem. My wife was a contract bridge addict and I was not annoyed by cocktail parties. My son gave me no trouble. I have relieved tension by a limited practice and local contract bridge. My exercise is farming, my boyhood occupation. The proposed medical reforms can wait for the next century.

Francis B. Sargent '19
Providence, Rhode Island

I had the good fortune to practice pediatrics from 1923 to 1970. The relationship I developed with my patients and their parents were most rewarding.

During the Depression of the thirties, everyone was broke. I collected less than half of what I put on the books. That did not include my charity work at several hospitals. We tightened our belts and accepted the situation.

As I reminisce, I realize I enjoyed every day of my practice. Physical stress, yes; not too much mental stress.

Hughes Kennedy, Jr. '21
Birmingham, Alabama

Early in my career I sought the counsel of Kenneth Blackfan, then Professor of Pediatrics at Harvard, a wise mentor. The piece of advice I remember best went something like this: "You'll encounter plenty of problems, but don't let them get you down. In time many of them will solve themselves." How true that turned out to be.

My only time of real stress occurred in the early fifties and took the form of a battle with the Dean of Columbia Col-

lege of Physicians and Surgeons, where I was head of pediatrics. He had threatened to take pediatric pathology away from pediatrics and submerge it in general pathology; and my disagreement with this arbitrary behavior was so intense as to cause me to submit my resignation. When the question was brought up for a faculty vote, no action was taken, and no recommendation made; the dean's threat was voided and I withdrew my resignation.

Rustin McIntosh '18
Tyringham, Massachusetts

I consider myself singularly fortunate. The challenges of my professional life have been on the whole very rewarding.

To this day I am an inveterate attendant at lectures and clinics at our superb institutions. The intellectual challenge of keeping abreast of all the remarkable advances in internal medicine is most gratifying.

With all of this I have had the additional rewards of good health as well as leisure time to enjoy my family, the cultural opportunities of Boston, and extensive travel.

To sum it up, I'm just a lucky guy.

Joseph Goldman '22
Boston, Massachusetts

Mental stress is more prevalent in a physician's early years when one is retiring debts and proving oneself, more physical in later years when the demands on time and body are constantly increasing.

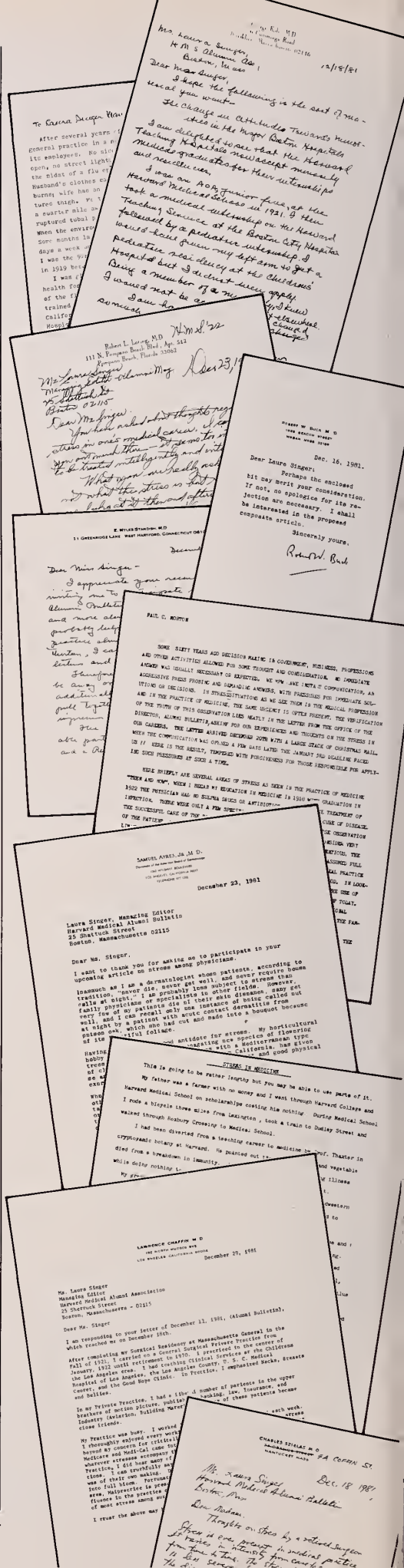
Fatigue and stress are not necessarily bad. Indeed, the contented, mild fatigue that comes from doing what one likes to do is a source of pleasure. The busier one is, the happier. It is the excesses which exact a heavy toll.

I've had many illnesses that should have ended my career, the most serious of which was post-op cardiac arrest. Each of these illnesses has caused mental and physical stress, but in the end I've learned more about the disease; and I hope it has made me a better doctor.

If not—what is life all about? I sometime wonder. But for my years I'd gladly go back to the stresses.

Robert L. Loring '22
Pompano Beach, Florida

I found the attitudes toward minorities difficult to deal with in my day. I was an AOA, junior five, at the Harvard Medical School in 1921. My medical internship was on the Harvard teaching service at the Boston City Hospital,



followed by a pediatric internship. I would have given my left arm for a pediatric residency at the Children's Hospital, but I did not even apply; being a member of a minority, I knew I would not be accepted and therefore went elsewhere.

George Kahn '22
Brookline, Massachusetts

The most stressful feature of my experience in medicine was the domination of medical practice by laymen, as exemplified by the authority of a hospital superintendant to fire a doctor for any reason, without consulting the medical staff. It is impossible for a physician to live up to principles of medical ethics under such control.

David H. Flashman '22
Taunton, Massachusetts

Inasmuch as I am a dermatologist whose patients, according to tradition, "never die, never get well, and never require house calls at night," I am probably less subject to stress than family physicians or specialists in other fields. Very few of my patients die of their skin diseases; many get well; and I can recall only one instance of being called out at night by a patient with acute contact dermatitis from poison oak, which she had cut and made into a bouquet because of its beautiful foliage.

When episodes of stress—professional or otherwise—do occur, I have found the most effective relief is to take positive action. If another person is involved, making direct contact, clarifying the situation and attempting to come to some agreement can prevent "stewing" and loss of sleep.

Having a hobby is a good antidote to stress. My horticultural activity—introducing and propagating new species of flowering trees, shrubs and vines from areas with a climate similar to that of southern California—has given me a stimulating interest and a good source of exercise.

Samuel Ayres, Jr. '19
Los Angeles, California

Strange as it may seem, my main source of stress during the practice of medicine was financial. From the period 1951-62, I was putting in about forty hours at Harvard and receiving only \$4,000 a year in compensation. I enjoyed the work, but would have liked to receive adequate pay. (Fortunately, I was able to support my family by supplementing my salary in private practice.)

Randolph K. Byers '21
Milton, Massachusetts

A brief list of stressful events in my medical life:

1) As a medical student working on a project to investigate the onset of function of pig pancreas: many hours spent in the slaughterhouse to get embryos, and then in the lab.

2) The hopelessly non-effective care of dying infants at the Children's Hospital, San Francisco, during the influenza epidemic in the summer of 1918.

3) The anxiety of a future hanging on the competitive written and oral examinations for a house officer appointment at New York's Bellevue Hospital.

4) As a twenty-three-year-old ship's doctor enroute home from India during a typhoon, the challenging and fortunate success of suturing a sailor's evulsed finger.

5) Adjusting to my first scientific address at a badly organized scientific session of the American Heart Association: no slide projector available!

6) As a U.S. Army major, the death of a nineteen-year-old soldier from a brain abscess: inadequate supplies of penicillin.

John J. Sampson '20
San Francisco, California

When I began practicing in 1922, the physician had no sulfa drugs or antibiotics to treat infection, and few specific drugs for the control or cure of disease. The successful care of the patient depended upon careful history-taking, close observation, a complete physical examination, and what we would now consider to be very limited laboratory tests. As physicians we were required to be extraordinarily thorough and conscientious, and to assume total responsibility for each case. We often developed close, personal involvements with our patients and their families.

Technical advances, emergency room services, and intensive care units have changed all that by dividing and compartmentalizing patient care. The individual physician no longer seems to bear the burden of total responsibility—but at what cost, I wonder, in personal satisfaction?

In spite of these unfortunate trends in our profession, I would most certainly choose medicine as a career if I had to do it again.

Paul C. Morton '22
New York, New York

I retired at the age of sixty-nine and am now eighty-nine. I have had a very satisfying life in medicine and am now enjoy-

ing the fruits of an almost nonstressful existence. When I first opened my general practice, however, conditions were difficult. I worked in a new housing development built by an industry for its employees. There were no sidewalks, street lights, or address numbers on the houses. Sewer ditches remained open in the unpaved streets. And all this in the midst of a flu epidemic.

One rainy night lightning struck a house. A man whose clothes had caught fire suffered first- and second-degree burns, his wife's ankle was fractured in six pieces, and their child had a fractured thigh. We transported them by hand litter to a waiting ambulance a quarter mile away. I lost a young diabetic girl in 1919 because insulin was not yet available.

Adrian G. Gould '17
Studio City, California

After completing my surgical residency at the Massachusetts General Hospital in 1921, I carried on a private practice in general surgery in Los Angeles until my retirement in 1970. I worked long hours, and too many days each week. I thoroughly enjoyed every working day, and was not bothered with stress beyond my concern for critically ill patients.

During my later working years, malpractice litigation came into full bloom. In the Los Angeles area, at least, this has had a major effect on the practice of surgery, and I believe is the cause of most stress among surgeons in all specialties today.

Lawrence Chaffin '17
Los Angeles, California

Stress is ever-present in medical practice. It varies in intensity from time to time, from case to case, and from specialty to specialty. The stress of a surgeon is more severe than that of a medical man who can change his diagnosis or treatment the next day. The surgeon has only one chance: He has to do it now or not at all.

By experience and adaptation, the surgeon develops a protective coating, like a bullet-proof vest, to shield himself from any harm that stress could cause him. He must learn to treat each case as a mechanical problem. The absolute belief that he is doing his best helps, but it does not conquer stress.

In time he begins to like stress and enjoys living with it. It is the thing he misses most when he retires.

Charles Sziklas '21
Nantucket, Massachusetts

□

Tenure - Malpractice
Grant renewal - Getting
Competition -
Misdiagnosis
Ph
RELAX
Loan payments -
RELAX

One for the Heart

A Simple, Noncultic Technique

by Laura Singer

Rarely do a physician's medical and non-medical interests intersect as they have for Herbert Benson. While an undergraduate at Wesleyan University, he developed a fascination with comparative religion and wrote several papers on the mystics—an interest which would one day resurface as an integral part of his medical research. In the meantime, Benson went on to HMS, graduating in 1961 and returning four years later to the Departments of Medicine and Physiology to study induced hypertension in the monkey.

For more than a decade, Benson's work has been a marriage of two unlikely bedfellows: science and religion. What began as a tentative and cir-

cumscribed study of the effect of Transcendental Meditation on blood pressure has blossomed into a multifaceted exploration of the behavioral component of illness, using non-medical therapies and borrowing heavily from the healing practices of non-Western cultures.

His research to date has done much to buttress the argument for the mind-body link in health and disease: A recent study of Tibetan monks, for example, scientifically measured their ability to withstand cold in the Himalayan foothills through a sophisticated meditative technique which regulates body temperature. The study, it is hoped, will have practical application for the treatment of ailments such as Raynaud's disease. But for Benson, a cardiologist by training, it is in the area of stress that his work in behavioral medicine has its roots.

Stress, according to Benson, is "any situation which requires behavioral adjustment," adding that it is a person's perception of an event—rather than the event itself—which is the critical factor. "Physicians are constantly forced to adjust to new, often difficult, and unpredictable situations," Benson says, "and in this respect a doctor's life can be extremely stressful."

"On the other hand, it is sometimes the resultant effects of our practices on our families which create the greatest problems. We may be able to respond readily to the adjustments which our work requires, but what becomes stressful are the adaptations needed at home."

"For some people, of course, sitting quietly with nothing to do is actually more stressful than being in perpetual motion, constantly bombarded with decision-making situations. Again, the important thing is one's perception of

Herbert Benson '61 is Associate Professor of Medicine at HMS, and Director of the Division of Behavioral Medicine and of the Hypertension Section at Beth Israel Hospital.

ctice - National Boards -
 ublished - Hypochondriacs - Hospital politics -
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 osis - ICM - Match Day -
 physician surplus - Air money payments -
 Grand Rounds -

R E L A X

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what requires behavioral adjustment."

Much of Benson's work is devoted to the alleviation of stress by means of a non-cultic technique which elicits the so-called "relaxation response." The technique involves four essential components: (1) Sitting quietly in a comfortable position; (2) Closing the eyes and relaxing the muscles; (3) Becoming aware of one's breathing; (4) Repeating a word, sound, or prayer in phase with the breathing, disregarding all other thoughts as they occur.

The relaxation response is a set of physiological changes which was first observed in the cat by the Nobel laureate, Walter Hess. Hess reported that there exists an area in the hypothalamus which, when stimulated, causes decreased levels of epinephrine and norepinephrine, as well as a marked decline in blood pressure, heart rate, and rates of metabolism, respiration and

skeletal muscle blood flow—the exact opposite of the phenomenon that Harvard's Walter Bradford Cannon had described earlier as the "fight-or-flight response."

"In modern society, when faced with situations that we perceive as stressful, we respond with the same set of physiologic changes that were used for survival during the hunter-gatherer epoch," Benson explains. What once helped protect man from the enemies which stalked him has become then, something of an internal predator—with the result that continued and inappropriate elicitation of the fight-or-flight response by different forms of environmental stress now contributes to a number of ailments, notably hypertension and other cardiovascular disease.

Currently, many of Benson's patients are people with high blood pressure who have been able to control

their condition while reducing their dependence on traditional hypertension drugs. (The side effects of the relaxation response, he is quick to point out, are essentially the same as those associated with prayer.) Among his patients are a number of physicians who, Benson finds, are reluctant to take excessive amounts of medication.

According to Benson, people whose use of the relaxation response would be more preventive than therapeutic are frequently deterred by the problem of finding the requisite ten to twenty minutes, twice a day, necessary for realizing the optimum effects of the technique.

Recent studies, though, have indicated that the relaxation response can be elicited during exercise. While jogging, for example, one would focus on his breathing, or on the cadence of his feet; or while swimming, on his strokes.

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